EFFECTS OF INCREASED FQHC REVENUE ON COMMUNITY HEALTH CENTERS

FINAL REPORT

August 13, 1992

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Policy Research, Inc.

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This study owes its existence to the cooperation and assistance of the staffs of nine primary care clinics designated as Federally Qualified Health Centers and officials from six state Primary Care Associations and Medicaid agencies. Despite their busy schedules and heavy work loads, they located detailed data, consented to extensive interviews, and generously agreed to read and verify case study reports. Their dedication, help, and support is most appreciated by the authors.

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EXECUTIVE SUMMARY

The Federally Qualified Health Centers (FQHC) program, enacted by Congress in OBRA-89, requires cost-based payments to federally-funded community health centers as well as other qualifying health clinics. This new mandated system of Medicaid and Medicare payments represents a major federal initiative to promote access to primary care within underserved communities.

This report presents the findings of an assessment of the early implementation and impact of the Medicaid Federally Qualified Health Center (FQHC) legislation. The study, which was funded by the Bureau of Health Care Delivery and Assistance, examines the experience of states, community and migrant health centers (C/MHCs), and similar primary care clinics in shifting to cost-based Medicaid reimbursement.

The Medicaid provisions of the FQHC program are still in the initial stages of implementation, and draft regulations for Medicare have only recently been published. The assessment in this report provides early information on the ways in which some states and centers are adapting to the new reimbursement system and enhanced Medicaid revenues. Although the findings of the case studies may not reflect the experience of all centers, they suggest important trends and issues for the future.

STUDY GOALS AND METHODOLOGY

As an early implementation study, the project was intended to provide BHCDA with in-depth information on implementation issues at both the state and individual center levels. The project also incorporates elements of a "best practices" study, which identifies and examines states in which implementation proceeded rapidly, as well as centers that have been able to quickly use FQHC-generated revenues. Specific study objectives include the following:

- Examination of the processes and issues occurring in individual states during implementation of the FQHC program
- Examination of implementation problems and issues experienced by individual centers
- Analysis of the response of centers to the potential to improve programs by using funds available as a result of enacting the FQHC legislation
- Assessment of data requirements and the feasibility of documenting the revenue impact of FQHC reimbursement, as differentiated from other enrollment and service changes affecting total Medicaid revenues

The project involved development of detailed case studies of the experience with FQHC by nine C/MHCs located in six states. Site visits, including related interviews and information-gathering on-site, were the primary data source for this study. This information was supplemented with background information on federal policy, state Medicaid programs, and individual center operations.

IS THE FQHC PROGRAM ACHIEVING ITS OBJECTIVES?

A primary objective of the FQHC legislation was to improve reimbursement for Community-based primary care by reducing the shift in costs from Medicaid to Public Health Service (PHS) grant funds. Ensuring reimbursement of the reasonable cost of services to Medicaid recipients would eliminate the need to use grant funds to subsidize services to these patients. PHS grant funds could then be directed toward providing care for the uninsured, supporting needed services that are not Medicaid reimbursable, and generally expanding capacity to care for the medically underserved.

Medicaid Reimbursement

The experiences of the centers and states in this study suggests that, even at this early stage of implementation, the program is achieving its objectives. State payment methodologies are largely based on previously developed cost-based systems, such as the Rural Health Center (RHC) and the Federally Funded Health Center (FFHC) programs. Although problems achieving comparable definitions make calculation of changes in payment rates difficult, available data indicate substantial, but variable, increases_ In the two Texas centers, reimbursement per encounter more than tripled. In a rural Illinois center that was already on cost-based reimbursements as a Rural Health Clinic, the rate jumped by 48 percent.

Ultimately, how effectively the FQHC program reduces the PHS grant subsidy of Medicaid services depends on the extent to which centers actually receive revenue at the FQHC rates, Although higher rates are being translated into increased reimbursements, the extent to which revenues are approximating costs varies. In the visited states, payment delays result from three factors:

1. ***Transition Effects. The*** process of phasing in a new payment system typically involved establishing interim rates below cost and resulted in substantial retroactive payments. In addition, there have been delays in conducting reconciliations. As a result, virtually none of the visited centers had yet experienced a "full" effect of FQHC.

2. ***Payment Methodologies That Build in Sizable Reconciliations.*** Most states have adopted a methodology that, when fully implemented, should yield revenues that are close to the costs of service in that year. However, in one state, the methodology provides for interim rates and continuation of end-of-year reconciliations.

3. ***State Payment Delays.*** In some states, particularly Rhode Island and Illinois, payment delays have resulted from state fiscal difficulties and not from the FQHC payment methods themselves.

Medicaid Patients

Despite payment incentives for centers to enroll more Medicaid recipients, increased services to Medicaid patients is as yet not a major effect of the FQHC program. Although virtually all of the centers reported that their Medicaid caseloads were increasing, this increase was not due to deliberate

outreach efforts. Only three of the nine centers have responded to the FQHC program by attempting to market their services to Medicaid recipients who had not previously used the centers. Because most of the centers had reached their current physical and staff capacity, limited outreach efforts, whether to Medicaid or other potential users, is not surprising.

Medicaid enrollments at the centers are increasing, largely because of general economic conditions, higher unemployment, and expanded Medicaid.eligibility, particularly coverage of children at higher income levels. Implementation of the Omnibus Budget Reconciliation Act of 1989 (OBRA-89) requirements for outstationing of Medicaid eligibility workers is also a key factor. Centers that had outstationed workers were actively engaged in identifying potentially eligible patients and in assisting them to enroll in the program. For these centers, rising Medicaid caseloads represent a conversion of existing patients from "uninsured" to "Medicaid" status. Targeting efforts toward Medicaid patients raises implicit conflicts for some centers. On the one hand, provision of care to the *underserved*, which clearly includes the Medicaid population, is a primary mission of the centers. On the other hand, some centers articulate their mission as providing for the uninsured.

The centers and states view the FQHC program from different perspectives. For the centers, FQHC ensures full payment from Medicaid and permits the use of grant funds to build capacity for the uninsured and underserved. In contrast, some state Medicaid agencies interpret the FQHC program as an opportunity to improve access to cost-effective care for Medicaid recipients and, ultimately, to provide program savings. These perspectives may conflict, particularly if costs for Medicaid agencies continue to increase, and if the agencies do not perceive increased access for Medicaid recipients. As FQHC reimbursement systems become more stable over time, the interaction of FQHC and improved services for Medicaid patients should be carefully examined.

WHAT HAS BEEN THE EARLY EXPERIENCE WITH IMPLEMENTING THE NEW PAYMENT SYSTEMS?

Implementation of the FQHC program at the study centers proceeded fairly smoothly, even at sites that lacked highly trained financial staff. In large part, we attribute the smooth implementation to the training provided through the Primary Care Associations (PCAs), which helped to prepare centers for an unfamiliar process. However, note that we base this conclusion on the experience of a few successful states and centers.

Development of Payment Methodologies

The process of developing payment methodologies at the state level included all parties--Medicaid, PCAs, and individual centers--in a relatively open atmosphere, in which discussion and involvement were typically welcome. In most states, the PCAs took the lead in representing the health centers' interests. With some instances of friction, issues relating to the treatment of specific costs appear to have been resolved through discussion and negotiation. The factors contributing to this smooth process varied among the states and included: (1) support of (or, at least, lack of resistance to) the FQHC program on the part of state Medicaid agencies, (2) a belief on the part of the Medicaid agencies that the FQHC would have a minor impact on total Medicaid spending; (3) expertise and knowledge made available by the PCAs, and (4) previous discussions of C/MHC reimbursement issues and prior relationships developed between Medicaid and the PCAs.

Following the initial implementation, the state Medicaid agencies continue to grapple with management problems, such as the need for considerable staff resources to handle the retroactive reconciliation process. Some centers are experiencing extended payment delays, and specific payment policies (such as whether to allow a particular cost to be included in the rates) continue to be debated.

Impact of Federal Regulatory Process

Virtually all of the states cite the lack of regulations from the Health Care Financing Administration (HCFA) as the single more important problem in implementation. Without clear guidance from HCFA, the states were forced to determine the most appropriate methodologies to implement the requirement that payments be "based upon, and cover the reasonable costs of providing services to Medicaid beneficiaries." As a result, the states clearly believed themselves to be at some risk, as HCFA might conceivably adopt regulations to exclude certain aspects of their methodologies, possibly resulting in disallowances of federal matching payments to the state Medicaid programs. Some states adopted fairly simple rules, which were based on the use of previously approved cost reports. These states did so, in part, in order to remain flexible, in adapting to any new rules HCFA might later promulgate.

Expanding the FQHC program to include Medicare in OBRA-90 complicated and slowed the process of developing implementation rules for Medicaid. Medicare regulations were issued in June of 1992, while this report was being finalized. The implications of the Medicare rules for eventual Medicaid regulation remain unclear.

The absence of Federal regulations has resulted in a patchwork of varying state Medicaid payment methodologies for implementing the FQHC Program.

- States exclude different services (e.g., obstetrics) from the all-inclusive payment rates.
- Three of the states used the FFHC cost report, and three use the RHC model.
- Two states established prospective-payment systems with no reconciliation, whereas the other four use all-inclusive rates with a reconciliation.
- Two states apply limits on administrative/overhead costs. One uses a complex system of screens. Three established overall limits on payments, and three did not.

WHAT IS THE REVENUE EFFECT OF FQHC?

Increases in Medicaid Revenue

For some centers, FQHC appears to be having an impressive effect on total Medicaid revenues. Of nine centers in this study, one center experienced a decrease in actual Medicaid revenues received, but the others have seen increases between 1989 and 1991 which ranged from 72 to 339 percent. When reconciliations for the Year are finalized, the increases will be even larger. For

example, the one center experiencing a decrease should received 50 percent more Medicaid revenue than it did for the calendar year 1989; one Texas Center has a projected nine-fold increase.

At the same time, the experience to date is insufficient to permit assessment of the long-term revenue effect of the FQHC program. On one hand, some centers have received first-year payments in 1991 which include transition reconciliations from 1990, thus overstating annual revenue. In other cases centers are owed substantial lump-sum payments, either because the reconciliation process has been delayed or because state payments have lagged considerably.

Problems of Measuring Revenue Effects of FQHC

To appropriately account for retroactive payments, FQHC revenues should be attributed to the year in which services were rendered. Current BHCDA reporting on the BCRR calls for annual reporting of actual receipts, regardless of the year in which services were rendered. BHCDA needs to be able to disaggregate retroactive payments from total Medicaid revenues in order to accurately monitor trends in Medicaid revenues under the FQHC program.

Even after the transitional period is completed, documenting the impact of FQHC cost-based rates will be complicated. Differences in the definitions of key terms, such as an "encounter," might limit the on-going monitoring of trends in Medicaid revenues to C/MHCs under the FQHC program. Expansions in Medicaid eligibility and covered services can be expected to increase revenues, irrespective of changes in payment rates. Three major improvements in Medicaid--improved eligibility for children, expanded services covered under EPSDT, and outstationing of eligibility workers at C/MHCs and disproportionate-share hospitals--were adopted and implemented at about the same time as the FQHC program. Understanding the effect of cost-based reimbursement alone requires a model that separates (1) enrollment increases, (2) intensity effects (more visits per patient), (3) case-mix effects (different services received by patients, and (4) revenue effects (higher rates per visit).

Concerns of State Medicaid Programs

Although the overall revenue impact of FQHC is far from clear at this time, states are evidently concerned about the cost implications and in two states were skeptical about the program. To some extent, these concerns reflect a prevailing **view** that cost-based reimbursement encourages inefficiency. However, they also reflect the fact that the cost-based rates are substantially higher than previous payment rates, and that expenditures for C/MHC services are likely to increase substantially. Comments provided by state agencies suggests the following:

- ***State agencies are looking at FQHC in isolation.*** Although the FQHC revenue increases are substantial, payments to these programs still represent a very minor part of total Medicaid spending. For instance, in Texas, payments to C/MHCs rose from about $1 million to $4 million. However, these expenditures amount to only 0.7 percent of total Medicaid spending on physician services.

- ***State agencies are concerned about the potential long-term impact of "look-alikes."*** Although the level of concern about look-alikes differs among respondents, some states were clearly aware of the growing number of look-alikes and of issues

surrounding the extent to which waivers should be provided. Illinois, in which the majority of FQHC centers are look-alikes, specifically mentioned the reported increase in spending on look-aiikes as an issue.

Addressing these concerns calls for careful analyses that are beyond the scope of this study. In some states, the FQHC program has resulted in a shift of expenditures from one line of the Medicaid budget to another. For instance, in Illinois, centers that were previously reimbursed as "physician services" are now being paid as "community health centers." This shift, coupled with the large number of look-alikes in that state, partly accounts for the cited increase in spending in the "community health center" fine, from $6 million to more than $50 million.

HOW ARE CENTERS USING FQHC-GENERATED REVENUES?

Centers appear to be using FQHC revenues to meet urgent needs that have accumulated as a backlog of unfunded priorities. With a primary focus on improving the basic infrastructure for expanding service capacity, centers have looked at the needs of both their current catchment areas and their larger surrounding communities. Two centers have used FQHC-generated revenues to start new satellite sites, and two more are considering initiating such services.

Centers view their FQHC-generated revenues as an opportunity build future capacity with the following implicit hierarchy:

- ***Building construction and renovation to provide more practice suites and related administrative and service areas.*** Almost all ***of*** the centers were operating under severe space constraints, which inherently limited their abilities to improve or expand services. Two of the nine sites are being forced to replace their buildings.

- ***Increase staff (physicians and mid-levels), particularly in the high-demand specialties of pediatrics and perinatal care.*** At least ***five*** of the centers have had systematic difficulties filling staff vacancies and are improving compensation.

- ***Identify service gaps and Purchase necessary equipment and/or hire staff to provide these services.***

Center Decision-Making Process

When the FQHC legislation was first enacted, some officials expressed concern that the centers might adapt poorly to the new financial environment. We found that the visited centers have diligently prepared for FQHC implementation, and that they have allocated their revenues with some caution. Most of the centers had, already developed formal or informal strategic plans, which identified major needs and future directions.

To some extent, the current state of FQHC implementation may encourage centers to use FQHC-generated funds for one-time expenditures. Spending plans may reflect the transition period, with its sizable retroactive reconciliations. The reality is that lump-sum payments, which are not tied to immediate service costs, are in many respects like a grant. As such, they are **easily allocated to**

capital and equipment expenses. Indeed, BHCDA policy encourage such uses. In the future, centers are likely to bill for, and to receive, reimbursements that are closer to Medicaid service costs. At that time, expenditure patterns may change.

The centers are skeptical about the long-term future of the FQHC, which also affects their decisions on the use of revenues. Factors promoting skepticism include: (1) slow and irregular payments in some states, (2) delayed reconciliations, which leave centers at risk of having to pay back funds to the state, (3) state budget crises, which lead to the feeling that the program may become a target for budget reductions, and (4) concern about the interrelationship of higher FQHC revenues and levels of future BHCDA grant funding.

Future Policy Concerns

These concerns will most likely continue to be issues as the program is implemented. Although the BHCDA has clearly stated that revenues directed to expanding or improving patient services will not be offset against grant funds, these issues continue to cause some concern, confusion, and apprehension among the centers. A recent General Accounting Office report, which specifically criticizes the application of this policy to FQHC revenues, can only add fuel to these concerns.

The centers and BHCDA will need to adapt to the new fiscal management demands generated by the FQHC. Cost-based reimbursement carries with it the potential of lump-sum payments--and of lump-sum pay-backs to the states. This environment calls for practices that are associated more frequently with business management than with the management of non-profit, grant-centered organizations--for example, holding reserves to ensure the availability of funds to cover pay-backs resulting from reconciliations. BHCDA is developing a policy which addresses these short-term uses of funds, but more clarification and guidance to the centers on the treatment of FQHC-generated revenues may be in order.

Over the long term, the success of the FQHC program will be judged not merely by its ability to generate Medicaid revenues, but by its impact on access and services for medically underserved populations. Partly as a result of a transition period, FQHC-generated revenues yield large lump-sum Medicaid payments. As Medicaid revenues begin to flow more smoothly, the impact of can be expected to influence the treatment of the BHCDA grant, which can be redirected to provide care for more patients or to establish new services.

I. OVERVIEW OF THE STUDY

This report presents the findings of an assessment of the early implementation and impact of the new Federally Qualified Health Center (FQHC)' legislation. The study, which was funded by the Bureau of Health Care Delivery and Assistance (BHCDA), examines the experience of states, community and migrant health centers (C/MHCs), and similar primary care clinics in shifting to cost-based Medicaid reimbursement. This chapter provides an overview of the study. It is organized into four parts: background, objectives, methodology, and limitations of the research.

A. BACKGROUND

Approximately 600 non-profit organizations receive federal funding to provide primary care services for about 6.4 million low-income, migrant workers and homeless Americans. Federal grants, under Sections 329, 330 and 340 of the Public Health Service Act, provide only partial support for these services. The mission and purpose of the Federal grant programs is to promote "development and operation of primary health service systems in medically underserved areas for medically underserved populations" (Bureau of Health Care Delivery and Assistance, 1991). Grantees also receive revenues from Medicaid, Medicare, state and local governments, other third-party payers, and the patients themselves.

For years, Medicaid payments for services rendered at C/MHCs have been well below cost. In 1989, estimated Medicaid revenue per medical encounter for the average C/MHC was slightly under $40.00, well below the average center's total cost per encounter of $77.00 (Lewis-Idema, 1990 and 1991). The centers have had little financial flexibility to recover these costs from private sources. Virtually all patients have incomes below 200 percent of the federal poverty levels. More than 40

[1]For simplicity, this report will use the initials "FQHC" to refer to both the legislation and the entities qualifying for reasonable cost reimbursement under the statute. Since eligible providers include C/MHCs, programs for the homeless, and designated look-alikes we will generically refer to them in this report as "centers."

percent of the patient population is uninsured, and only 14 percent has private insurance (Lewin ICF, 1992). As a result, centers have had to cover the difference between revenues and the cost of service to Medicaid patients primarily from their BHCDA grant funds--funds that increased only marginally during the late 1980s.

1. FQHC **Program--Congressional Intent and Major Provisions**

The Federally Qualified Health Center legislation, enacted under the Omnibus Budget Reconciliation Act of 1989 (OBRA-89), seeks to eliminate the shifting of costs from Medicaid to PHS grant funds. The Medicaid FQHC law, effective April 1, 1990, mandated that state Medicaid programs reimburse for ambulatory **services** rendered by Federally Qualified Health Centers (FQHCs) on the basis of reasonable costs. In 1990, Congress broadened the scope of cost-based reimbursements for C/MHCs by mandating Medicare FQHC payments under the Omnibus Budget Reconciliation Act (OBRA-90). The Medicare FQHC program is effective as of September 1, 1991.2

Congressional intent to eliminate grant subsidies for Medicaid and Medicare patients was clearly articulated by Senator John H. Chafee on behalf of the co-sponsors of "The Community Clinic Improvement Act":

> It seems to me we have been neglecting an important, and perhaps critical, resource in our fight to improve services and access: community health centers...[grant subsidies for Medicare and Medicaid patients] put demands on the already limited public and private grants and has hampered the clinics' ability to provide care to the uninsured. Moreover, because health clinics serve a disproportionate share of low-income and Medicare and Medicaid patients, there is virtually no capacity to shift costs. The net effect is that the ability of health clinics to care for the working poor is slowly but surely being sapped of its strength.[3]

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[2]OBRA-90 provided clarifications regarding entities that qualify for FQHC-covered services and the cost-based methodology under Medicaid. It also extended the FQHC program (and cost-based reimbursement) to Medicare services. The Medicare statute does not permit two-year waivers for look-alike centers. It does include all Federally-Funded Health Centers, receiving cost-based reimbursement under Medicare-Part B as of January 1, 1990. This report refers to "Medicaid-FQHC" to distinguish our focus from the Medicare provisions.

[3]*Congressional Record,* June 16, 1989, p. S6813.

By assuring reasonable levels of Medicaid and Medicare reimbursement, Congress sought to achieve three interrelated objectives:

- Eliminate the shift in costs from Medicaid and Medicare to Federal grant funds;
- Free-up Federal grants to finance primary health care services for other low-income and uninsured individuals who comprise the C/MHC's target populations; and
- Expand C/MHC capacity to enhance scope of services and increase the number of individuals served within their respective communities.

The Medicaid legislation included three interrelated provisions:

1. ***Defines FQHCs*** to include (1) federal grantees under Sections 329 and 330 (Community and Migrant Health Centers or C/MHCs); (2) grantees under Section 340 (Health Care for the Homeless); (3) programs operated by Indian tribes; and (4) health centers whose characteristics meet the statutory and regulatory guidelines for federal funding, but that do not receive grant support (the so-called "look-alikes"). For the latter group of centers, the Medicaid statute permits waiver of regulatory requirements for up to a maximum of two years.

2. ***Defines FQHC services*** as the core set of medical services, previously specified in legislation under the Rural Health Clinic Act and all other ambulatory services covered in the state plan.

3. ***Establishes reimbursement requirements*** that states pay FQHCs 100 percent of the costs that are reasonable and related to the cost of providing FQHC services and all other ambulatory services included in the state Medicaid plan.

2. Administrative Authority

At the federal level, responsibility for implementing the FQHC is split between the Health Care Financing Administration (HCFA) and BHCDA HCFA establishes reimbursement rules, consistent with its responsibility for administration of the Medicaid program. The statute provides that federal grantees under Sections 329, 330, and 340 are automatically eligible for FQHC reimbursement. In addition, BHCDA makes recommendations to HCFA for entities qualifying as of look-alike centers according to established standards for designation. HCFA formally has final authority over approving

such centers, including those with waivers. Rules outlining the requirements that might be waived in this process were issued during 1990.

Medicaid is a federal-state program under which each state develops and implements its own program within parameters established by federal legislation and regulations. HCFA provides regulatory guidance within which the states develop their reimbursement plans and methodologies. In 1990, HCFA issued brief State Medicaid Manual Instructions, which required states to pay 100 percent of the reasonable cost for FQHC ambulatory services (Health Care Financing Administration, 1990).

> The state payment system may utilize prospectively determined payment rates or may pay interim rates subject to reconciliation at the end of a cost-reporting period. Irrespective of the type of payment method utilized, the state must determine and assure that the payments are based on, and cover the reasonable costs of providing services to, Medicaid beneficiaries.

The State Medicaid Manual Instructions did not provide guidance on a number of critical methodological issues, including:

- The definition of "reasonable costs" beyond stating that they could not pay more than allowed under Medicare rules
- The use of caps or screens to define reasonableness
- Specifying whether retroactive reconciliations were required
- The use of a standard cost report

As of the summer of 1992, Medicaid regulations for FQHC had not been issued. Medicare FQHC was enacted in OBRA-90, one year after the Medicaid legislation, with an effective date of September, 1991. HCFA began to develop Medicare regulations. Regulations for Medicaid FQHC were expected to follow. The Medicare regulations were published, as a final rule with comment period, on June 12, 1992. The regulations note that Medicaid rules are being developed separately; the schedule for these rules is not known.

The continued lack of clear regulatory guidance from HCFA left state Medicaid agencies and C/MHCs on their own as they developed implementation plans for FQHC. Throughout 1990 and 1991, the state Primary Care Associations (PCAs),[4] which represented the centers and Medicaid agencies engaged in detailed and extensive negotiations on reimbursement methodologies, cost finding, and cost reporting requirements (MDS Associates, 1991). The outcome of the negotiations was a variety of payment methods, standards, and reporting requirements, each reflecting the idiosyncracies of the individual states. Although FQHC provisions were legally effective on April 1, 1990, the extended negotiation process, coupled with the need for centers to prepare new cost reports, delayed actual implementation in a number of states. At the end of 1990, about one-third of the states had begun paying centers under FQHC rules, and all states had implemented by the middle of 1992 (MDS Associates, 1991 and 1992).

B. OBJECTIVES OF THE STUDY

Because cost-based reimbursement under the FQHC is likely to have a significant impact on the operations of C/MHCs, it is important to understand how the program is being implemented at a state level; its effect on the finances and management of the centers; and how the centers are using newly available resources. BHCDA has contracted with Mathematica Policy Research, Inc. (MPR), with subcontracts to MDS Associates and the Sheps Center of the University of North Carolina, for a study to assess the implementation of FQHC legislation. The primary study objective is to provide BHCDA with information on the effect of the FQHC on the operations and future plans of individual centers, so that the agency could provide additional assistance and direction to its grantees early in the implementation period.

[4] PCAs are nonprofit entities whose membership includes both federal Community and Migrant Health Centers and nonfederal grantees. Their mission is to promote development of community-based primary care in their states. PCAs represented their members in discussions with state Medicaid agencies on implementation of FQHC.

This study is an early implementation assessment that examines the ways in which centers are adapting to the new fiscal environment offered by FQHC. Specific study objectives include the following:

- Examination of the processes and issues occurring in individual states during implementation of the FQHC program
- Examination of implementation problems and issues experienced by individual centers
- Analysis of the response of centers to the potential to improve programs by using funds available as a result of enacting the FQHC legislation
- Assessment of data requirements and the feasibility of documenting the revenue impact of FQHC reimbursement, as differentiated from other enrollment and service changes affecting total Medicaid revenues

As an early implementation study, the project was intended to provide BHCDA with in-depth information on implementation issues affecting C/MHCs. As such, it focuses on implementation both on the state-wide and individual-center level. The project also incorporates elements of a "best practices" study, which identifies and examines states in which implementation proceeded rapidly, as well as centers that have been able to quickly use FQHC-generated revenues. The study explored issues that can be grouped into five major areas of research and that are primarily descriptive in nature:

1. Implementation of the FQHC at the state level (Chapter II)

- What was the process of state-level negotiations on the FQHC, and who was involved? What were the major issues, from the perspectives of the Medicaid agencies and the centers, and how were they resolved?
- What type of reimbursement methodologies have been adopted, and how do they differ among the states?
- What problems and issues are likely to affect implementation in the future?

2. Implementation of the FQHC at the center level (Chapters III and IV)

- What is the current status of implementation at the center level? What changes in financial management and billing have been required?

- What has been the financial impact, to date, of FQHC on center revenues?

- What issues or problems have individual centers encountered when implementing FQHC?

3. Center planning for and implementation of FQHC programs (Chapter IV)

- What are C/MHC management priorities and planning activities related to FQHC? What is the center decision-making process regarding use of enhanced revenues?

- What types of activities are C/MHCs considering or implementing?

- Can the extent of activities supported by FQHC-generated revenues be quantified or documented at this time? If not, when might such documentation be available?

4. Documenting the revenue impact of FQHC (Chapter V)

- What types of data are available from centers to estimate increases in Medicaid revenues due to FQHC?

- Can increases in Medicaid revenues due to improved payment rates be disaggregated from increases due to higher enrollment or expanded service coverage?

5. Implications of implementation experience (Chapter VI)

- What additional documentation and reporting needs are required to monitor the operation and implementation of the FQHC program?

- Are any legislative, regulatory, or policy changes needed to improve the implementation and eventual impact of FQHC?

This study is not an overall evaluation of the impact of the FQHC. Indeed, such an evaluation at this time would be premature. Although most centers in the United States are now paid according to FQHC-established rates, the majority have not been paid under this methodology for a long enough period to fairly judge its implementation and impact.

C. METHODOLOGY

The study involved detailed case studies of the experience with FQHC of nine C/MHCs located in six states. The case study results were used to develop comparative descriptive analyses and to identify generalizable problems and practices in implementation. In addition, the study also involved exploring a methodology for estimating revenue effects of the FQHC.

Site visits, including related interviews, were the primary data source for this study and took place between December 1991 and March 1992. This information was supplemented with background information on federal and state policy and individual centers. This background information was gathered through interviews and from secondary data sources. Data on Medicaid revenue primarily relates to 1991.

1. Background Data

Because the FQHC is a new program, few reviews or compendia of written material directly address these issues. Other secondary sources relevant to program implementation include:

- ***BHCDA Program Guidances.*** We reviewed (1) the grantee program guidance for the 1991 grant cycle, (2) standards for FQHC qualification for look-alike centers, including specification of the federal grantee requirements that BHCDA is willing to waive for as long as two years, and (3) BHCDA's guidance on use of Excess Program Income. The last document is particularly important, as it provides the framework within which grantees can use new revenues to expand services without having to offset new revenues generated through FQHC against the BHCDA grant.

- ***HCFA State Medicaid Manual Instructions. This*** brief guidance provides the policy framework within which states developed their payment methodologies.

- ***The Issue Briefs on FQHC. These*** have been published by the National Association of Community Health Centers (NACHC) since late 1989. They were developed to assist state and regional PCAs in their negotiations with state Medicaid agencies. As a result, they were an excellent resource for identifying the payment and implementation issues of concern to centers.

- ***The National Governors' Association (NGA) monograph on the FQHC, "Enhancing Primary Care Systems Through Federally Qualified Health Centers." This*** monograph resulted from a workshop on FQHC involving both Medicaid agencies and centers, sponsored by the NGA in February, 1991. It provided a useful resource for

identifying Medicaid agency concerns and subjects of negotiation between the two parties (Medicaid and C/MHCs).

- ***MDS Associates' "Implementation Status of Federally Qualified Health Center Reimbursements."*** This report for the NACHC was based on a survey of state PCAs in the autumn of 1991. It includes detailed information on state payment methodologies and site-specific payment rates. Preliminary responses to the survey were used in the site-selection process to (1) confirm the initiation date for FQHC payment, and (2) assure that selected states represent a variety of payment methods.

- ***C/MHC Information Reported in the Bureau Common Reporting Requirements (BCRR) Database.*** Data on utilization, staffing, and revenues are reported annually by all grantees under Sections 329 and 330. The BHCDA maintains these data in computerized files (called BHCDANET). The data files are also available at the Sheps Center. The Sheps Center abstracted descriptive data from the 1990 BCRR, including urban-rural location, total medical users, number of sites within the entity, total FTEs, number of primary care encounters, encounters per user, encounters per FTE, Medicaid as percent of total revenue, and amount of the 330 federal grant.

During the design phase for this study and as part of the process of protocol development, interviews were also conducted with personnel from NACHC, NGA, and HCFA. Frequent discussions were held with BHCDA to ensure that the project team was up to date on the evolving FQHC environment.

2. Site-Selection Process

The project called for in-depth case studies of nine health centers in six states. To permit some intrastate comparisons, two sites were to be located in each of three states. The basic approach to site selection was a two-step procedure, in which we first identified states in which FQHC implementation was sufficiently far along to warrant inclusion in the study, and then selected a mix of centers within those states.

a. Site-Selection Criteria

Consistent with the study objectives, the centers that were selected for site visits were among those that had had at least one year of experience with FQHC reimbursement at the time of the

visits. Thus, although the sites reflect a mix of large and small, and urban and rural programs, they are not a random sample of C/MHCs. Rather, these centers constitute a purposive sample drawn to provide illustrations of how different types of centers, operating in differing environments, are using FQHC in order to improve their capacity to provide care for the underserved.

As is common in case studies of a limited number of sites, there were more criteria for site selection than could meaningfully be reflected in the final group. Of the four criteria for selecting states, the first two were the principal parameters used to identify the initial round of states:

- ***The state had an approved FQHC Medicaid plan.*** Although FQHC was effective on April 1, 1990, some states were able to pass the appropriate legislation and have their plans submitted and approved faster than others.

- ***The state Medicaid agency had begun paying according to the state's established interim payment method by January 1, 1991.*** Because site visits were planned for early 1992, the project team believed that this criterion would assure that centers would have had enough experience with FQHC to generate the information needed for the study. For purposes of site selection, "interim payment method" did not mean that the state had completed cost reconciliations, but, rather, that reimbursement methods had been revised and that centers were billing under new procedures.

- ***The states would reflect geographic diversity. This*** would be done to the greatest extent possible within the primary criteria.

- ***There should be a substantial differential in Medicaid payment rates pre and post-FQHC implementation.*** In order to analyze the impact of the FQHC payment methods and rates, the amount of enhanced revenues must be reasonably sufficient to allow for expansion of services or patient bases.

The basic criteria for individual sites were as follows:

- ***A Minimum of Five Years of Operation. This*** criterion would ensure that the center would have had sufficient time to be fully integrated and institutionalized within the community, and that its staff and board would have had sufficient experience in establishing and managing fiscal and organizational policies and operations.

- ***Billing Medicaid Under FQHC Rules Since January, 1991.*** This criterion would help to ensure that the center would have had enough experience with this new payment methodology to enable the project team to collect the information needed to conduct the analyses.

- ***Inclusion of One Look-Alike.*** Although this project did not focus on specific issues related to look-alikes, inclusion of one such site would permit examination of

differences and similarities in the FQHC eligibility, application, and implementation processes between the look-alikes and the 330 centers.

- ***Strategic and Long-Term Planning Process.*** For some sites, the amount of revenue enhancement from FQHC will be considerable. Thus, planning for the use of these revenues is a reasonable expectation. The project team hoped to identify the centers that have systematically planned to use these newly available funds and to analyze their planning processes and experiences.

- ***Representativeness of C/MHCs, Measured by Differences in the Number of Users, Encounters, Staffing, Number and Types of Services Provided, and Number of Sites.*** This criterion would allow examination of the differential impact of increased revenues on small and large centers, and of differences in how new funds are used.

- ***Variation in the Proportion of Total Revenues Received From Medicaid.*** This criterion would allow the project team to examine differential experiences of centers according to their initial dependence on Medicaid.

b. Initial Identification of States and Sites

The initial list of potential states and sites was developed on the basis on telephone inquiries with informed observers of FQHC implementation. We used the criteria listed above as well as preliminary information collected in the information review process, in order to contact regional PHS offices and to give them information about the study's goals and methods. The regional offices were asked to confirm the extent and nature of FQHC implementation within their regions and to provide useful information for identifying individual states and sites to be included in the study. All regional offices were able to make state-specific recommendations and, in a few cases, site-specific recommendations. These discussions produced a list of 16 states that potentially met the state-specific criteria: California, Colorado, Delaware, Florida, Illinois, Kentucky, Maryland, New Jersey, New Mexico, Pennsylvania, Rhode Island, Texas, Utah, Virginia, West Virginia, and Wisconsin.

Approximately 260 sites within the 16 nominated states were potentially eligible for inclusion in this study. The second step in the identification process was to contact the state and regional PCAs in order to inform them of the study goals and methods, reconfirm information on FQHC implementation, and request site-specific recommendations. Information on candidate states was also reconfirmed with NACHC. We also solicited site-specific recommendations from state and national

reimbursement specialists, nationally recognized consultants and experts on primary care systems, the president-elect of the National Rural Health Association, and others.

This process yielded a list of nine potential states, each of which had recommendations of sites for inclusion in the study. The project team used the data sources listed previously to develop a list of 18 sites in 9 states, which was submitted to the BHCDA All of the 18 sites met all of the initially established criteria. From the list of recommended sites, the study team collaborated with BHCDA in selecting the final nine sites.

3. Site Visit Protocols

Each site visit (and case study) involved three types of data collection: (1) telephone and/or on-site interviews with state Medicaid agencies and PCAs, (2) background information on each center gathered from the BCRR, and (3) detailed on-site interviews. The protocols used With the PCAs, state Medicaid agencies, and center interviews appear in Appendix B.

a. PCA and Medicaid Agencies

These interviews focused on the state-wide issues of implementation, including the process of negotiations and identifying on-going issues of concern. The interviews yielded detailed information on state payment methodologies and state-wide impact of the FQHC. This information provided the basis for analyses of the differences in implementation among the states and in-depth assessment of implementation problems and concerns. The state-wide issues also provided the context for examining the environment within which individual centers currently operate and plan for the future under the FQHC.

b. Center Profiles

The profiles were a tool for organizing background information obtained prior to the site visit and quantitative data collected on site. The profile includes background information on FQHC implementation by the center, as well as descriptive data on the center, including users, services,

staffing, revenues, and expenditures. BCRR data reported annually by centers was the primary source of information for these profiles. Data on Medicaid users, which are not reported on the BCRR, had been previously abstracted from grant applications by the BHCDA and were available to the project team. Data organized in the profiles were revised for inclusion in each site visit report, as appropriate.

c. Site Visit Interview Guides

The site visit interview guide included core subjects to be explored with each site and specific questions tailored to each site. Subjects covered in the interview guides included:

- History and operations of the center
- Services provided prior to implementation of FQHC
- Center experience with FQHC implementation, including changes needed to adapt to the new reimbursement methods
- Revenue impact of FQHC
- Plans for using FQHC-related revenues, including both the planning process and specific expansions/improvements

Each site visit lasted two days and involved a two-person team. Four of the visits were conducted by the Sheps Center of the University of North Carolina, and four were conducted by MDS-MPR. Consistency between the interview teams was achieved by using a detailed interview guide. The first site visit, which also served as a pretest for the protocols, included staff from all three entities. The protocols were then jointly revised. Extensive site visit reports were completed after each trip and shared among all project staff. Telephone conferences were held to share perceptions and ensure similar data were being collected.

During the site visits, every effort was made to meet with all key personnel involved in planning for FQHC implementation and service expansion. These individuals varied among the centers, and

on-site interviews were tailored appropriately. The following types of persons were interviewed on-site:

- Executive director
- Medical director and other clinical staff
- Financial staff (including accountant, where necessary)
- Board chairman/key committee members
- Other staff involved in FQHC-related activities, as appropriate to each site

Case studies were prepared for each of the individual sites, and were submitted separately to BHCDA under this contract.

D. LIMITATIONS

The main limitation to this case study approach is the difficulty in drawing broad conclusions on the basis of the experience of a small group of centers. We deliberately selected study sites in order to include those that had been receiving FQHC-based reimbursement for some period of time. Furthermore, the six states were those that had implemented FQHC quickly. Almost by definition, these are states in which the negotiation process on implementation proceeded relatively expeditiously. Elsewhere in the country, extensive negotiations between PCAs and state Medicaid agencies have continued for some time; indeed, as of the summer of 1992, final agreements on cost reports and methodologies have not been achieved in some states.

As is evident in the case studies and comparative analyses, FQHC is still an evolving program. Even in states and sites that implemented new reimbursement methods early, revenue increases have been slow, and methodologies are still being revised. This study provides early findings on both the issues likely to influence implementation in the future and on the ways in which centers are planning to use expanded revenues in order to improve services and enhance the delivery system for their low-income and uninsured patients.

II. FQHC IMPLEMENTATION AT THE STATE LEVEL

The provisions of the Federally Qualified Health Center (FQHC) legislation included in the Omnibus Budget Reconciliation Act of 1989 (OBRA-89) apply only to Medicaid. As such, the required changes in the reimbursement of qualifying clinics are to be carried out by Medicaid programs whose characteristics vary significantly among the states. The provisions require states to pay 100 percent of the reasonable costs of most services. The law also directs that the new payments become effective for "calendar quarters beginning on or after April 1, 1990, without regard to whether or not final regulations to carry out such amendments have been promulgated to such date" (Section 6404). To date, no regulations have been proposed by the Health Care Financing Administration (HCFA). Therefore, the states, have had to develop the rules and plans for implementing the cost-based payments to centers.

Table II.1 summarizes specific aspects of FQHC implementation in the study states, including the date that FQHC payments were made available to community and migrant health centers (C/MHCs), the number of qualified centers within each state, the existing clinic reporting forms used as a model for the states' cost reports, a very basic description of the FQHC rate-setting methodology, the level of cost controls in the form of caps and screens, and the regularity of payments. Two points are worth noting:

1. For almost all of the states involved in this study, estimates of the financial impact of FQHC reimbursement at the state level for the first year of the program were not available, primarily because:
   - Final cost settlements for all FQHCs had not been determined
   - State fiscal difficulties have led to slow and erratic payments in some states
   - Prior to FQHC implementation, the idea of combining Section 329, 330, and 340 grantees (and, of course, the new category of "look-alikes") was unfamiliar, and no historical data on payments to these centers as a group were readily available

TABLE 11.1

SUMMARY INFORMATION OF FQHC IMPLEMENTATION
IN SIX STUDY STATES

Date FQHC Payments Were Available to CHCS	
Illinois	April 1990
Maryland	April 1991
Rhode Island	July 1990
Texas	August 1990
Virginia	April 1990
Wisconsin	January 1991
Number of FQHCS	
Illinois	**65,** including 34 "look-alikes"
Maryland	11, including 1 "look-alike"
Rhode Island	4
Texas	28
Virginia	17
Wisconsin	7
Model for Cost Report	
Illinois	FFHC (Federally Funded Health Center)
Maryland	FFHC
Rhode Island	FFHC (option of RHC for rural sites)
Texas	RHC (Rural Health Center)
Virginia	RHC
Wisconsin	RHC
Basic Description of Methodology	
Illinois	Prospective all-inclusive per visit rate; no reconciliation
Maryland	All-inclusive interim per visit rate and reconciliation
Rhode Island	Prospective all-inclusive per visit rate; no reconciliation
Texas	All-inclusive per visit rate and reconciliation
Virginia	A&inclusive per visit rate and reconciliation
Wisconsin	(a)all-inclusive interim per visit rate and reconciliation; (b) option for **fixed** rate and no reconciliation; **(c)** "wrap around" payments to sites with contracts **with HMOs**

TABLE II.1 (continued)

Current Caps and/or Productivity Screens	
Illinois	Overall cap ($69); administrative cap (30%)
Maryland	Primary care caps ($66.24 rural; $104.51 urban); administrative cap (33.3%)
Rhode Island	Overall cap (from FFHC rate, currently $63.00); productivity screens (from FFHC)
Texas	Administrative cap (30%)
Virginia	None reported
Wisconsin	Overhead cap (30%)
Regularity of Payments	
Illinois	Very irregular
Maryland	Lag in reconciliation process
Rhode Island	Backlog in payments
Texas	Lag in reconciliation payments
Virginia	Lag in reconciliation process
Wisconsin	Lag in reconciliation process

- Other Medicaid initiatives were taking place concurrently with FQHC implementation, making the effects of a particular program difficult to isolate
- The definition of an "encounter" changed, precluding pre- and post-FQHC comparison of encounter rates

2. Certain issues common to all of the states in this study have been identified, most notably, the absence of federal directions and guidelines. Some states were, therefore, reluctant to develop final policies and procedures. This was especially evident when a site visit team would request a copy of the state's FQHC policies only to learn that they were in draft form and would not be finalized until the federal regulations are issued.

This chapter provides information on FQHC implementation with particular attention to issues of continuing concern to state Medicaid officials. These include FQHC payment methodologies, estimates of financial impact, and issues that arose during the implementation process. For each study

state, we provide background information such as the number of FQHCs within the state, and descriptions of policy issues such as the state's fiscal, administrative, and Medicaid concerns at the time of FQHC implementation. We then describe the FQHC rate determination methodology, cost report information, the financial impact of FQHC reimbursement from the state perspective, and specific state implementation issues. The individual case study reports that are submitted as a separate deliverable provide additional details about these issues.

A. FQHC IMPLEMENTATION IN ILLINOIS

The Illinois Department of Public Aid was prepared to process FQHC cost-based payments on the OBRA-89 effective date Of April 1, 1990. The relatively quick transition to cost-based reimbursement to FQHCs was due primarily to the Illinois Department of Public Aid's previous experience with five urban CHCs that began receiving cost-based reimbursement in the mid-1970s. Indeed, since 1985, the Illinois Primary Care Association (PCA) had been requesting that the Department of Public Aid and the state legislature extend cost-based reimbursement to all CHCs. After an attempt to achieve this goal through state legislation failed in the spring of 1989, the PCA and the Department of Public Aid scheduled a meeting in December of 1989 to discuss the issue. When OBRA-89 was passed, the meeting, originally intended for negotiation, became the first FQHC planning meeting.

According to the Illinois informants to this study, this history, described as "fortuitous" by the Executive Director of the Illinois PCA, set the stage for the process of extending cost-based reimbursement to all FQHCs relatively quickly and smoothly. Specifically, the Illinois site visit team identified two key factors that contributed substantially to the transition. First, the major parties interested in FQHC implementation--the Illinois Department of Public Aid, Illinois PCA, and CHC administrators--had already established lines of communication and working relationships. Second, anticipation of cost-based reimbursement Prior to the OBRA-89 federal mandate meant that the

principles of cost-based accounting were already familiar to the Department of Public Aid officials, PCA leadership, and CHC directors.

To date, Illinois has a higher proportion of look-alikes than any other state. Of its 65 centers, 34 were look-alikes and 31 were Section 329, 330, or 340 grantees. More than one-half of the current group of look-alikes are in the Chicago area,. including 5 clinics of Cook County Hospital and 15 satellite clinics of the Chicago Department of Health. According to informants, the number of look-alikes is expected to continue to increase as a result of the promotion of FQHC reimbursement by the American Medical Association, PCA, and enterprising consultants. The latter group includes a Chicago lawyer who was said to have "boasted that her fee of $25,000 will get you guaranteed approval." In recent months an average of seven look-alikes have received approval each month. At least 15 hospitals were known by the Department of Public Aid to be seeking to qualify their outpatient departments as look-alikes. Of the 31 grantees, 14 were Section 330 CHC grantees with 22 satellite clinics, 1 was a joint 329/330 grantee, 1 was a Section 329 grantee, and 1 was a. Section 340 grantee.'

1. FQHC Rate Determination Methodology

Illinois centers have several options for the determination of their initial FQHC reimbursement rate. After receiving notification of approved FQHC status, a center could elect to:

- Submit an audited financial report for a recent 12-month period to the Department of Public Aid, which would be used to calculate an all-inclusive reimbursement rate for use as the billing rate for the coming year
- If a recent la-month audited financial report is not available, submit at least 6 months of financial and utilization data to the Department of Public Aid for calculation of an interim rate, which would then be reconciled with actual costs

[1]The information from the Department of Public Aid that there are 31 grantees is not inconsistent with the number of grantees cited in the preceding paragraph. Health centers with multiple sites have the option of billing under one Medicaid provider number or billing under separate provider numbers for the main clinic and the satellites, an option that some grantees have exercised.

- Accept an interim rate of $37, which is a conservative rate that is very likely to be less than a calculated cost-based rate, and then file a report to reconcile this rate with actual costs

- Use a current reimbursement rate from another major payer source, such as the Rural Health Clinics (RHC) rate or Federally Funded Health Center (FFHC) Medicare rate, as an interim rate and file a reconciliation report to determine the actual cost-based rate

The interim rates described in the last three options, which require a reconciliation with actual costs, are acceptable to the Department of Public Aid as an initial FQHC reimbursement rate. However, this is a one-time-only reconciliation. Subsequent all-inclusive rates reflect 100 percent reasonable cost-based reimbursement_

The Illinois Department of Public Aid has adopted an FQHC methodology that results in a prospective all-inclusive rate (exceptions noted below). The all-inclusive rate negates the need for periodic reconciliation. A slightly modified version of the FFHC Medicare cost report form has been adopted as the FQHC Medicaid cost report form. FQHCs submit this form in March of each year for determination of a center-specific inflation-adjusted reimbursement rate that will be effective for a one-year period beginning the following July 1. Once determined, the rate is jointly accepted by the Department of Public Aid and each center as representing 100 percent reasonable cost-based reimbursement for Medicaid services, with no reconciliation needed. However, FQHCs wishing to present a case for unusual circumstances that substantially changed their financial position may do so through an appeals process.

Special features of the all-inclusive rate include the following:

- The rate is prospective and adjusted for inflation.

- The FQHC cost report form is supplemented with special report forms for dental and pharmacy services (the **"add-ons").**

- There is an overall cap of $69, which does not include the inflation factor and the add-ons.

- There is an administrative cost cap of 30 percent of total allowable costs.

- Prenatal and obstetric care are billed fee-for-service.
- Inpatient care visits are billed fee-for-service.

According to one informant, the FFHC Medicare cost report form was adopted by Illinois Department of Public Aid because "using this form would make the conversion easy and eliminate problems." It was a form that was already familiar to most FQHC administrators. Rather than setting a new rate year that was coincidental with the beginning of each FQHC's fiscal year, Illinois elected to have a universal date of July 1 for the beginning of the new rate period for all FQHCs.

All FQHCs are required to file the FQHC cost report form in March of each year on the basis of information from the last audited financial report. Thus, for example, for centers whose fiscal years end in June, the financial data used to calculate the new rate would be at least one year old when the new rate became effective. This issue was resolved by including an inflation factor in the rate calculation.

The Department of Public Aid saw the need to develop an FQHC billing form as an opportunity to expand its data base by collecting more comprehensive data, such as CPT procedure codes. The FQHC billing form "mirrors physician's fee-for-service billing" and will allow the Department of Public Aid, for example, to calculate the average number of encounters for various procedures for use in detecting outliers. The Department of Public Aid views this analytic capability as "putting teeth into the program," but has not yet taken steps toward implementing it.

2. **Financial Impact of FQHC Reimbursement**

Precise comparisons of the levels of statewide Medicaid reimbursement pre-and post-FQHC implementation are complicated by two factors:

1. Prior to FQHC implementation, centers were reimbursed in a variety of ways. Most grantees were paid as "private physicians" with individual practitioner billing numbers. Hospitals that qualified their outpatient departments as look alikes were reimbursed through the hospital part of the Medicaid program; thus, historical reimbursement data are not readily available and would require special data runs.

2. Although statewide Medicaid encounter rate data are available pre- and post-FQHC implementation, they are not comparable because the contents of an encounter have changed. The pre-FQHC implementation Medicaid rate did not include all procedures that took place during the encounter; procedures were billed separately from the standard encounter rate. The FQHC encounter rate is all-inclusive.

In April of 1989, one year before FQHC implementation, Iliinois had 14 Section 329 and 330 grantees (with 16 satellite clinics), which received about $6 million in Medicaid reimbursement. In 1992, according to the Illinois Medicaid agency informants to this study, Medicaid reimbursement to 65 FQHCs, including the 34 look-alikes will be approximately $50 million, a figure that is expected to increase to between $70 and $75 million in 1993, largely due to continuing federal approval of applications for look-alike status. Prior to FQHC implementation, Medicaid's fee-for-service reimbursement to these centers was $18 per encounter; however, this rate excluded the costs of any procedures performed at the time of the visit. Under FQHC reimbursement, health clinics receive an average all-inclusive rate of $60 to $70 per encounter, with a range of $47 to $84. The Department of Public Aid estimates that other providers are receiving Medicaid reimbursement at an estimated 30 to 50 percent of costs.

3. State Implementation Issues

Informants from the Illinois Department of Public Aid offered several recommendations and lessons learned from the FQHC implementation experience.

a. No Evidence That FQHC Reimbursement Caused Medicaid Clients to Switch to Different Provider Types

Specifically, staff of the Department of Public Aid had hoped that the FQHCs would publicize their interest in serving Medicaid clients, who would use the FQHC for primary care and become less reliant on hospital emergency rooms. According to the Department's informants, this did not occur.

b. Look-Alikes Have Proliferated

This is Illinois' most serious problem, according to the Department of Public Aid informants. Their concern is not with the concept of look-alikes but rather with their seemingly "uncontrolled" growth. The informants specifically requested that the site visit team relay their concern in the project's Final Report, including their recommendation that Health Resources Service Administration and HCFA implement more stringent requirements for providers applying for look-alike status, such as on-site inspections and audits. The RHC application criteria were recommended as a model. The Illinois PCA also supports "careful restrictions and monitoring" of look-alikes.

c. Inadequate Lead Time for Implementation

Illinois' previous experience with cost-based reimbursement prior to the OBRA-89 mandate is credited with the early full implementation of FQHC reimbursement. However, the informants realize that Illinois was exceptional in this regard and believe that the few months lead time before the April 1, 1990 effective date was not a reasonable expectation for implementation.

d. Federal Guidelines and Other Formal and Informal Direction Are Lacking

This issue was reported to have complicated the implementation process. It still concerns the Department of Public Aid. Illinois has fully implemented the FQHC payment methodology, yet the informants are aware that federal guidelines, if they are incompatible with Illinois policies and procedures, may negate much of their time, effort, and expenses.

e. The State Is Experiencing a Fiscal Crisis

A special concern of the Department of Public Aid is the fiscal situation, which has caused delays and interruptions in FQHC payments. The Department estimates a current 120-day payment cycle (other informants suggest a much longer payment delay) and has tried to ameliorate this situation by offering interest-free loans that are recovered as the provider's claims are processed through the system. Almost all of the FQHCs have taken advantage of this program.

f. Inclusion/Exclusion of Services in Reimbursement Rate

Other issues arose in the implementation process which were worked out primarily by the Department of Public Aid and the Illinois PCA. These issues dealt mainly with the inclusion or exclusion of certain services in the all-inclusive rate. Examples of these services include dental care (dentist encounter fee was set at $54; costs of special procedures, such as root canal and dentures, are factored into the annual cost report), Norplant (FQHCs are reimbursed for the encounter during which the drug is implanted; the cost of the drug is factored into the annual cost report), obstetric services (excluded from the all-inclusive rate; billed fee-for-service), and inpatient services (excluded from the all-inclusive rate; billed fee-for-service).

B. FQHC IMPLEMENTATION IN MARYLAND

Maryland is a rate-setting state and was already familiar with setting up cost-reporting systems for hospitals. As FQHC cost-based reimbursement was being implemented in Maryland, other Medicaid reforms were being initiated, in particular, the Maryland Access to Care (MAC) Program. In addition, FQHC implementation led to its own extension, called the Maryland Qualified Health Centers (MQHCs) Program. The MQHCs belong to a newly established category of provider, which is similar to the FQHC classification in organization and services offered, but are not federally designated as FQHCs. State regulations set a cap to the MQHC rates 100 percent of the lowest applicable FQHC rate for urban or rural centers. Cost reports are not required.

MAC is a managed care program that requires Medicaid patients to select a primary care provider for all non-emergency primary care services and to act as an authorizing agent for referrals for specialty care. Medicaid recipients who do not choose a MAC provider are assigned a provider by the state on the basis of the recipient's residence and/or billing and provider history. Eligible MAC providers include all FQHCs, all MQHCs, other eligible free-standing clinics, private physicians, eligible hospital outpatient clinics, and some county health departments. Providers will receive an

enhanced Medicaid rate, or payment for each enrollee per month, for serving as MAC providers. FQHCs will continue to receive FQHC payments, as mandated by federal law.

Maryland is unique in the rate-setting arena, given its substantial experience in establishing cost-based rates in other health care sectors (for example, hospitals). In designing the FQHC rate methodology, the Mid-Atlantic Primary Health Care Association, in concert with Maryland member centers, was involved in meetings with Medicaid officials to discuss FQHC cost-report and rate-setting issues. The seemingly complex methodology may well reflect Maryland's experience in setting prospective payment rates for hospitals.

As of February 1992, one FQHC is a look-alike, one is a Section 329 provider, one is a Section 340 provider, and eight are Section 330 providers.

1. FQHC Rate Determination Methodology

Maryland FQHC reimbursement is based on an all-inclusive per-visit rate. The cost report is a modified version of the FFHC cost report. The FQHC cost-reporting methodology is relatively complex, with various features designed to control costs (for example, an administrative cap), to compensate centers for specified high-cost services (for example, obstetrics and radiology), and to take inflation into account. There is an overall cap set at 125 percent of the group median. Separate interim rates are established for primary care and dental services.

Centers complete cost reports in accordance with the Principles of Reasonable Cost Reimbursement (42 CFR 413), the Provider Reimbursement Manual (HCFA Publication 15-1), and the Medical Care Program's Free-Standing Clinics regulations (COMAR 10.09.08). The FQHC cost report covers the centers' most recent fiscal year. To achieve a common accounting period, each center's rate is indexed forward to a common date by using the increase in the Medical Care Services portion of the Consumer Price Index for Baltimore from the midpoint of the cost report year to the midpoint of the rate year. This, in effect, takes into account inflation for the months between the cost reporting period and the effective date for payment of the interim rates.

Each year, the Maryland Medicaid agency sets a cap for maximum reimbursement of primary care and dental care services. Separate caps are set for urban and rural providers. On the basis of annual cost reports that are indexed for inflation, FQHCs are ranked (within each of the service and area categories) from the lowest to the highest cost per visit. The FQHC cap per visit is set by:

- Identifying the 50th percentile of Medicaid visits (median cost per visit)
- Limiting FQHC payment to 125 percent of the median cost per visit

For FY91 and FY92, the cost-based caps prior to adjustments are:

- Primary care
  FY91:$76.24 urban and $66.24 rural
  FY92:$104.51 urban and $66.24 rural
- Dental care
  FY91:$89.14 urban (no rural dental rates)
  FY92:$114.00 urban (no rural dental rates)

Add-on services that are not subject to the 125 percent cap include:

- OB/GYN services--direct costs for OB/GYN physicians, such as salaries and fringe benefits, and malpractice insurance premiums paid by the FQHC
- Radiology staff--direct costs for salaried professionals
- Costs related to off-site visits--costs of such encounters by a physician or nurse practitioner, including Healthy Start program
- Outstationing of eligibility workers--additional staff costs associated with the processing of Medicaid applications from pregnant women and children

These add-on costs are integrated into the Medicaid primary care rate in the cost-finding process, yielding an interim center-specific rate per Medicaid visit. If an FQHC has more than one site, it has a single rate that applies to all of its sites.

The FQHC reimbursement process includes audits and reconciliation of the interim payments with actual costs. As of February 1992, the audits had not yet begun. Auditing is anticipated to

begin within several months and will focus on the first two years of FQHC interim payments, beginning with April 1991 and retroactive to April 1990. Thus, it remains unclear whether and to what extent, centers' interim rates are on target, too high, or too low. Most FQHCs have been receiving interim payments for two years. Although not an articulated issue, the possibility of paybacks by some centers certainly exists. Provisions for paybacks, if any, have not yet been formalized, but options include lump-sum payback or reductions in current-year payments.

2. Financial **Impact of FQHC Reimbursement**

A comparison of pre- and post-FQHC Medicaid visit rates indicates a substantial increase in payments, approximately a doubling of the rate per primary care visit. Medicaid's pre-FQHC clinic visit payment was approximately $45 ($30 to $35 for private practice physicians); for FY 1992, the urban primary care cap was **$104.51.** As previously noted, none of the FQHCs have yet had their interim payments reconciled with actual costs, so that the statewide financial impact of FQHC reimbursement remains unknown.

In the future, the revenue impact of the FQHC provisions on the state as a whole and for individual FQHCs will be largely determined by the extent to which FQHCs successfully enroll Medicaid recipients and serve as major MAC providers for state assignment of the Medicaid population. Future assessment of the impact of FQHC should focus on the pre- and post-MAC periods in order to determine the extent to which FQHCs remain critical providers for the Medicaid population. In the same way that pre-FQHC Medicaid eligibility expansions increased the number of potential Medicaid patients and, therefore, Medicaid revenues to community health centers, MAC will now play a pivotal role in channeling Medicaid dollars among Maryland's community health centers and other providers.

3. State Implementation Issues

Implementation of FQHC cost-based reimbursement proceeded fairly smoothly in Maryland, largely because of the state's experience with cost-based rate-setting for hospitals and because the FQHC methodology was built on these methods. The FQHC methodology is relatively complex and required a significant expenditure of time and effort in negotiations to factor out such services as obstetric care and eligibility workers and the setting of caps and screens.

C. FQHC IMPLEMENTATION IN RHODE ISLAND

The process of FQHC implementation progressed relatively smoothly in Rhode Island. Rhode Island had policies and procedures in place for processing FQHC claims by September of 1990. However, the state's fiscal crisis and an outdated manual claims payment system have contributed to substantial delays in FQHC payments. The state Medicaid agency selected the FFHC cost report because some centers were already using it and the state could piggy-back on the FFHC methodology and rate cap.

Rhode Island has been especially hard-hit by the economic recession, which has led to an increased number of uninsured and families in poverty and, consequently, the number of persons covered by the state-financed General Public Assistance Program and Medicaid. Concurrent Medicaid eligibility expansions, particularly for pregnant women and children, also contributed to higher Medicaid enrollments. Statewide, 97,000 people are on Medicaid, approximately 10 percent of the state's population of one million. Medicaid currently accounts for 22 percent of the state's budget.

Rhode Island does not operate county or local health departments and thus does not have a direct capacity for delivering primary care. Rhode Island's financial support for primary care clinics that serve low-income and indigent populations is channeled principally to private community health centers. The state provides annual grants to designated health centers. Most recently, these centers shared a grant of $700,000.

The impact of Rhode Island's economic problems can be seen in the increasing demand for services in Rhode Island's four CHCs, particularly in the pediatric caseload, which has increased 22 percent during the last two years. The increasing dependence on CHCs for care was largely attributed by respondents to the reluctance of private physicians to accept low Medicaid payments.

Recently, the Rhode Island Department of Health hired a consultant to develop a state primary care plan. The assessment will focus on the status of primary care in Rhode Island, including where primary care is being delivered, access problems, and options for improving the capacity of the delivery system. This assessment will also include relevant activities of legislative commissions. Emphasis will be given to developing proposals for improving primary care, as well as decreasing the inappropriate use of emergency room services.

The primary care plan is expected to become an important cornerstone for improving access to appropriate care in the state. 'The extent to which the assessment will focus on FQHC reimbursement or its potential for increasing service delivery capacity is unclear. Similarly, it is premature to predict whether the primary care plan will provide any proposals about FQHC reimbursement or FQHC methodology.

In April 1991, there were four CHCs in Rhode Island, which operated six satellite clinics in addition to their main clinics. All four have obtained FQHC status. Although the Rhode Island PCA is focusing activities on the development of look-alikes, no applications by look-alikes had been submitted at the time of our site visit.

1. FQHC Rate Determination Methodology

Rhode Island has adopted an FQHC methodology that results in a prospective all-inclusive per-visit rate that does not require periodic reconciliation with actual costs. FQHCs use the FFHC cost report, which has been slightly modified in the non-allowable costs section. Rural FQHCs have the option of using the RHC report (currently, there is one rural FQHC in Rhode Island). The

FQHC payment cap is tied to the FFHC cap which was originally set at $62.00. In April of 1991, the FFHC payment cap and, by extension, the FQHC payment cap were increased to $63.00.

At present, there are no plans for reconciliation, unless required by federal plans. The use of the FFHC cost report and payment caps remains controversial, and centers may not recover their full costs for Medicaid clients. The FFHC methodology does not reflect the staffing structures of some CHCs, since FFHC is essentially based on a physician-driven model of care for Medicare patients. Thus, there are questions of where to allocate the cost Of mid-levels and support personnel such as counselors and WIC staff. Pharmacy and transportation services are also not included on the FFHC report and, therefore, are excluded from the FQHC cost report. This issue is important for FQHCs that are not at the cap, as higher allowable costs for those health centers would result in a higher approved billing rate.

The FQHC cost report also includes a number of caps and screens that are used in the FFHC cost report. For example:

- The HCFA screening guideline for staff physician on-site encounters is 2.4 encounters per hour. The physician encounters to be used in the determination of the rate is the greater of (1) the total physician on-site encounters or (2) the physician hours multiplied by the HCFA screening guideline.
- The allowable direct cost factor (or percent of encounters furnished by a physician) is the total physician encounters as a percentage of the total encounters.
- The guideline number of FTE physicians for the calculation of the rate is the greater of (1) the actual number of physician FTEs or (2) the minimum number of physician FTEs (1.0).
- The maximum number Of nonphysician staff is the guideline number of FTE physicians, multiplied by the HCFA guideline (4.0).
- The allowable nonphysician Staff is the lesser of (1) the maximum nonphysician staff, or (2) the actual nonphysician staff.
- The percentage of Staff is the allowable non-physician staff divided by the actual non-physician FTE.

Special features of the FQHC methodology include:

- A separate dental rate has been established for FQHCs that provide dental services.
- Prenatal services may be billed at a global rate (currently $750) or on a per-visit basis.

The decision not to have a reconciliation process was based on the serious lack of staff needed to conduct the reviews and the potential jeopardy of health centers that may be required to pay back sums in subsequent years of operation.

2. **Financial Impact of FQHC Reimbursement**

Prior to FQHC implementation, Medicaid reimbursed providers at the rate of $24 per visit. In July of 1990, retroactive to April of 1990, the Medicaid FQHC payment cap was set at $62, the same as the Medicare FFHC payment cap. On April 1, 1991, the FFHC and FQHC caps were increased to $63. The approved payment rates to FQHCs currently range from $47.50 to $63.00.

Staff at the Rhode Island Medicaid agency had expected that the Medicare FFHC cap would more than cover the Medicaid costs of FQHCs. This did not occur. According to the Director of the Rhode Island Health Care Association, a major reason that the costs were higher than the state had expected was the salary increases introduced to attract and retain physicians and specialized mid-level professionals. As the National Health Service Corps contracts expired, without replacements, health centers had to begin paying competitive salaries, which had a tremendous impact on their costs.

As of March 1992, Rhode Island FQHCs were negotiating with state officials for payment of a backlog of an estimated $2 million in outstanding FQHC billings. (This estimate is derived from figures from the health centers and the Rhode Island Health Care Association; it exceeds Medicaid's estimate.)

3. **State Implementation Issues**

The state's inability to make timely payments to FQHCs and problems with the cost report stemming from the lack of federal direction remain Rhode Island's major problems with FQHCs.

a. Payment Delays to FQHCs

Rhode Island's fiscal crisis and its manual billing/claims system are at the root of the state's major problem with FQHC payment delays. The FQHCs have experienced a lag in payments since FQHC reimbursement began and payments were held up until the next fiscal year. The delays have increased as the lack of Medicaid staff have resulted in the slow manual processing of claims. The FQHCs are not the only providers whose Medicaid payments are delayed, but their accounts receivable are lagging longer than those of other providers. Although hospitals also have some lag in their cash flow, they have an arrangement to receive Period Interim Payments. In December of 1991, overtime was authorized for the Medicaid agency to enable it clear up the backlog in Medicaid claims. The agency hopes to catch up to a reasonable payment lag within two months.

A continued FQHC payment lag will have a significant impact on the ability of the centers to redress problems of service capacity. Respondents noted that FQHCs that are already at service capacity are unable to increase recruitment efforts, raise salaries and compensation packages, or promote access through intensive community marketing and outreach programs. When regular and timely reimbursement of FQHC begins, it appears that health centers would first focus on stabilizing or increasing staff, thereby developing the capacity to serve more people.

b. Absence of Federal Regulations

This issue is reported to have delayed efforts to redesign the FQHC cost report. FFHC cost report was chosen for the FQHCs because the state felt that it would be pointless to develop a new cost report if federal FQHC regulations were to be issued within a relatively short time. In addition, administrative costs associated with the FFHC cost report are low. According to a PCA informant,

had she known the length of time required to issue the FQHC Medicaid regulations, the PCA would have pushed for a different cost report, as the Medicare FFHC report is not appropriate for Medicaid cost reporting..

D. FQHC IMPLEMENTATION IN TEXAS

The process of implementing FQHC reimbursement in Texas began in February of 1990 at a meeting of the state's Medicaid agency, the National Heritage Insurance Company (Medicaid's fiscal intermediary), and the Texas Association of Community Health Centers. The Medicaid plan amendment was submitted on June 29, 1990 (retroactive to April 1, 1990) and was approved in March of 1991. Payments became available to the centers in August of 1990, when new billing numbers were assigned to the centers. The cost report was finalized in December of 1990.

The relatively smooth implementation of FQHC reimbursement in Texas is credited to:

- The support for community health centers shown by Medicaid agency staff
- The information about FQHC reimbursement provided by the Texas Association of Community Health Centers
- Familiarity of some CHCs with cost-based reporting under FFHC, which provided an additional source of expertise for state agency and other CHC staff

Early in 1992, all of the 28 federally funded C/MHCs in Texas were FQHCs. The Medicaid agency believes that about three programs serving the homeless appear to be eligible for FQHC reimbursement but are not now participating. In addition, four or five look-alikes have submitted applications for FQHC status, including the Austin City/Travis County Health Department; none had been approved at the time of the site visits.

1. FQHC Rate Determination Methodology

Implementation of FQHC reimbursement proceeded in three phases:

1. For initial implementation, centers are billed 100 percent of charges on a fee-for-service basis.

2. Cost reports were submitted to reconcile payments with actual costs. The first set of cost reports covered the period from April 1990 through the end of a center's fiscal year; thereafter, centers submit cost reports within 90 days of the end of their fiscal year.

3. A cost-based encounter rate for each individual center, covering all services except family planning, Early Periodic Diagnostic, Screening and Treatment (EPSDT) program, and pharmacy, was established during the reconciliation process. On-site and desk audits of all cost reports were performed in October and November of 1991, and reconciliations were made in November. Beginning in 1992, the FQHCs are billing the cost-based encounter rate. Family planning, EPSDT, and pharmacy services continue to be billed at 100 percent of charges, but the costs are included in the annual reconciliation.

During the first phase, FQHCs had the option of billing at 100 percent of charges but could request lower reimbursement to protect against the possibility of paybacks after reconciliation. Some FQHCs requested the lower reimbursement; as they gain more experience with the FQHC reimbursement system, they have begun to request 100 percent reimbursement. There are no particular difficulties in the flow of payments to the FQHCs, which are regular and predictable.

The cost report being used is a modified version of the RHC cost report. The modifications allow for separate calculations of costs and revenues associated with family planning, EPSDT, and pharmacy services. Although these services are billed separately, they are factored into the calculation of the final cost settlement but are excluded from the calculation of the encounter rate.

Texas currently follows the principles of cost reimbursement in federal rules. Costs of support services, such as WIC and outstationed eligibility workers, are included in the cost base. The only screen is a limit of 30 percent of total costs for administration. There is no cap on the encounter rate.

2. Financial Impact of FQHC Reimbursement

Prior to the passage of the FQHC program, CHCs were reimbursed under the standard payment schedules for physicians and other services. They received on average $14 per physician encounter.

Total Medicaid payments were slightly over $1 million. According to the National Heritage Insurance Company, current FQHC encounter rates range from $33.97 to $91.82, with an average of $62.31, and represent a tripling or quadrupling of Medicaid revenues for some centers. Statewide reimbursement to FQHCs total about $4 million, $3.02 million of which was paid in retroactive cost settlements. However, these figures, represent the results of only the first six months of FQHC reimbursement, from April to September of 1990. As of April 1992, only a few reconciliations covering an entire 12-month period have been completed; as the remaining FQHCs complete this process, total Medicaid reimbursement to FQHCs is likely to increase.

Isolating the effect of FQHC reimbursement on Texas' Medicaid budget is difficult because other policy changes took place concurrently. In particular, Texas implemented the outstationing of Medicaid eligibility workers (called "integrated eligibility") at about the same time, leading to an increase in the proportion of CHC users who are enrolled in Medicaid.

3. **State Implementation Issues**

Although FQHC implementation proceeded easily, both the Medicaid agency and its fiscal intermediary have expressed some concerns about the program.

a. Expense and Level of Effort Required of Audits

One weakness identified by Medicaid and its fiscal intermediary is the level of effort required for audits and reconciliations. The National Heritage Insurance Company has assigned one person to work on FQHC, a staffing decision that helped to improve communications with the health centers. However, the reconciliations are expensive and consume significant amounts of the intermediary's time.

b. Longer-Term Cost Implications

Texas is facing a deficit of several billion dollars. The $3.02 million that Medicaid has already paid in reconciliations for the first year is low; as noted, when 12-month reconciliations with all of

the FQHCs are complete, FQHC will have an even larger budgetary impact. Texas Medicaid spends about $4 billion, $2 billion of which is for purchased services with its fiscal intermediary. Physician services account for $600 million of the intermediary's contract. It is worth noting that, despite the state's expressed concerns, Medicaid payments to CHCs currently amount to 0.7% of all expenditures for physician services.

c. Impact on Other Providers

Health department maternity clinics and private physicians have complained publicly that they provide services similar to those provided by FQHCs, yet receive much lower payments. For example, a health department maternity clinic receives $10 for the same type of prenatal visit for which an FQHC receives $40 or $50. The Departments of Public Health and Human Resources have discussed cost-based reimbursement for health departments. Medicaid personnel indicated in interviews that they have been advised that the statutory language referring to "cost" is "not intended to imply cost-reimbursement." They do not plan to move to cost-reimbursement at this time. Possible approval of look-alikes is a related concern (see the previous discussion of the expansion of look-alikes in Illinois and the budget implications for that state.)

d. Lack of Cost Controls

There was concern among respondents that FQHC reimbursement does not encourage efficiency or contain mechanisms to control costs. Although FQHCs do not appear to be spending inefficiently, there is some belief that, without screens or caps, such inefficiency will develop in the future.

E. FQHC IMPLEMENTATION IN VIRGINIA

On April 1, 1990, all CHCs in Virginia began participating in FQHC reimbursement. According to key informants to this study, the development of the FQHC reimbursement method was a "reasonably good experience." In the context of the rapidly expanding Medicaid budget, the increase in Medicaid expenditures resulting from FQHC payments was regarded as relatively small. In 1990,

Virginia Medicaid paid $1.2 million for federally funded C/MHCs, or 0.1% of a total budget of $987 million. The projected FQHC revenue increases of less than $1 million was therefore seen by respondents as a relatively marginal addition to the total budget. One Medicaid official contrasted FQHC payments to the relatively huge nursing home and hospital expenditures that the Virginia General Assembly monitors closely.

Virginia Medicaid officials reported that FQHC reimbursement offered the opportunity to expand services for Medicaid recipients. As proof of their ongoing commitment to service expansion, they pointed to the three Medicaid fee increases that were enacted over the last four years. As with the three previous rate increases, Medicaid viewed FQHC reimbursement as an opportunity to fulfill its mission and to work in partnership with providers in underserved rural and inner-city areas.

The Virginia PCA worked with the Medicaid agency and department-level officials to develop mutually acceptable policies and procedures for FQHC reimbursement. One testament to the excellent working relationships developed during this process was the "Friend of the Association" award given to the Medicaid staff for efforts "above and beyond the call of duty" in easing the transition to FQHC.

Virginia has 17 CHCs, all of which are reimbursed as FQHCs. To date, no look-alikes have been approved.

1. FQHC Rate Determination Methodology

Initially, FQHCs used the standard physician and ancillary services billing rates that were in effect prior to FQHC implementation to bill for each Medicaid service. The FQHCs submit a cost report according to a predetermined schedule. If costs are higher than revenues (a typical situation because of the low rates in effect prior to FQHC implementation), the health center receives a lump-sum payment for the difference. This approach offered two advantages to the new program. First, it ensured no interruptions in Medicaid revenues while the new reimbursement system was being developed. Second, using the comparatively low pre-FQHC billing rate as the initial FQHC billing

rate was a conservative approach that avoided the possibility that centers would be overpaid and, therefore, would have to pay Medicaid back. Because almost all Virginia FQHCs lacked prior experience with cost-based reimbursement, this transitional approach was favored by all participants.

At the time of the site visit to Virginia, the Medicaid agency was preparing to shift to an ail-inclusive rate. The new methodology involves establishing a limited number of visit codes, unique to FQHCs. Payment rates for each center will be established on the basis of their previously submitted cost reports. To bill Medicaid, center will use the cost-based payment rate, rather than the fee-for-service rate. Annual cost reports will be filed within 90 days of the end of a center's fiscal year. Medicaid has 180 days to review the report, to reconcile revenues received with actual payments, and to determine a settlement amount. Centers either will receive lump-sum payments (if they have been underpaid for their services) or will pay Medicaid back within 30 days (if they have been overpayed). This system is being tested at one center, and the conversion is expected to occur within a few months.

In the interest of rapid implementation, Virginia elected to use the RHC cost report form for FQHCs. Its main advantage was that most FQHCs were familiar with it (however, the Medicaid agency was not). A disadvantage was the need for modifications that when hastily applied, caused confusion when the word "Medicare" remained on the form. This oversight was corrected in subsequent printings of the form.

2. **Financial Impact of FQHC Reimbursement**

As of December 31, 1991, 12 Virginia FQHCs received an additional $308,152 in Medicaid revenues attributable to the FQHC program. For individual centers, the revenue increase ranged from $1,645 to $197,458, or an average of about $25,600 per center. Excluding the sole center with an exceedingly large revenue increase, the average for the remaining 11 centers was $10,063. However, these first-year revenues reflect only a partial impact of FQHC. By annualizing the initial

increases, the Virginia PCA estimated a total increase in revenues for all 17 centers of $801,502, or an average of $66,792 for each center.

3. State Implementation Issues

As previously discussed, Virginia Medicaid was philosophically in favor of FQHC reimbursement as a means to expand services to Medicaid recipients and to work in partnership with providers in underserved areas. The agency also viewed the increased payments to FQHCs in the context of a very large total Medicaid budget and, from this standpoint, did not view the program as a "budget buster." In addition, the excellent working relationship established with the Virginia PCA enabled implementation issues to be resolved in a mutually acceptable manner. This cooperation was largely due to the relatively small number of CHC grantees in Virginia. As a result, the FQHC statewide revenue increase of less than $1 million dollars formed a relatively small addition to the total Medical budget. This mutually supportive posture by the key negotiating parties led to the settlement of major issues.

F. FQHC IMPLEMENTATION IN WISCONSIN

According to key informants from Wisconsin's Medical Assistance Program, two of the major factors explaining the fairly rapid pace of FQHC implementation were:

1. The support of state officials, who recognized the usefulness of FQHC in targeting Medicaid dollars to inner-city and rural clinics, which service the neediest populations
2. The relatively low incremental cost of FQHC to the Medicaid program

Early in the FQHC implementation process, difficulties arose, which centered on the inclusion of health maintenance organizations (HMOs). The Medicaid agency's interpretation the FQHC legislation as allowing it to exclude Medicaid HMOs. This issue was sensitive and potentially divisive but was resolved through intensive negotiations and subsequent modification of the legislation.

In addition, the Wisconsin PCA greatly facilitated FQHC implementation. All study informants acknowledged the contributions of the association's Executive Director and Director of Technical Assistance. Of particular note were their initiatives in convening individual and group training sessions on the principles of cost-based accounting, their representation of Wisconsin's interests to national and state policy makers, and their ongoing technical assistance to the centers and Medicaid staff.

At the time of the Wisconsin site visit interviews early in 1992, Wisconsin had 7 FQHCs out of a potential pool of 20 health clinics. The FQHCs represent ail of the Section 329 and 330 grantees in Wisconsin. One look-alike had been approved but had not begun to receive FQHC reimbursement at the time of the site visits. The look-alike is a "quasi-public health department" in Milwaukee that is managed by the city health department but the services of which are provided under contract with a private practice provider group. According to informants from the Wisconsin PCA, hospital-based clinics have expressed some interest in look-alike status.

The potentially eligible programs that are not participating include a health center for the homeless and several tribal clinics. Medicaid agency informants reported that, despite having designed a simplified reporting method to facilitate their participation (the fixed-encounter rate option, which does not require the filing of a cost report), the Indian tribal clinics were the largest group of nonparticipating eligible health centers. One Medicaid official commented that, "the tribal clinics have the most difficulty in billing Medicaid, but they are the most in need. FQHC-Medicaid reimbursement added to their difficulties by requiring cost reports which they did not have the ability to complete, given their fiscal structures." Medicaid officials are continuing their efforts to assist the Indian tribal clinics in receiving FQHC reimbursement.

1. FQHC Rate Determination Methodology

Wisconsin's basic approach to FQHC cost-based reimbursement is to provide supplemental payments to the regular Medicaid payments made to CHCs, which includes urban health centers that

serve Medicaid patients assigned to them under the state's Medicaid HMO-waiver program. For each FQHC, a single global encounter rate is established for each Medicaid-certified provider. During the first year of **FQHC** reimbursement, the upper limit of a health center's encounter rate is based on its cost report and an analysis of the cost reports of all of the other FQHCs. In subsequent years the upper limit will be based on the previous year's encounter rate (adjusted for inflation), the center's cost report information, and changes in the utilization and delivery of services. A provision allows for adjustments to interim payment rates if the FQHC has had a substantial change in its scope or volume of services (because of the addition of a new provider, for example). This provision allows an FQHC to begin receiving a higher reimbursement sooner for an added service.

A reconciliation payment, if appropriate, is made on the basis of the submission and approval of an audited cost report. In the interim, an FQHC may submit quarterly, semi-annual, or annual cost reports; if a payment is indicated, the FQHC will be reimbursed for 85 percent of the reasonable costs that exceed all other reimbursements. An audited cost report is due to the Medicaid agency within 120 days of the end of the center's fiscal year and is used to establish the final reconciled payment.

Under an FQHC payment option, submission of a cost report is not required. All interested FQHCs may be assigned a fixed payment per encounter that will be based on the current Rural Health Clinic encounter rate. In return the FQHC agrees that the assigned rate represents 100 percent of reasonable costs and will not file a cost report. Once selected, the FQHC must retain this option for a period of one year. This option was developed to assist the smallest FQHCs and, in particular, to make it easier for the Indian tribal clinics to participate in FQHC reimbursement as look-alikes. To date, no clinic has requested the fixed rate.

FQHCs that have contracts with HMOs to serve Medicaid patients continue to submit claims for HMO enrollees through the HMOs. Reasonable costs in excess of the HMO reimbursements to the center will be reimbursed by the Wisconsin Medical Assistance Program through the quarterly or

semi-annual transfer payments (if this option is exercised) and reconciliation based on the annual cost report. Reasonable cost reimbursement will be paid to the FQHC for all services specified in the fiscal and contractual arrangements that the health center has with the HMO; thus, the Wisconsin Medical Assistance Program will provide reasonable cost reimbursement for a service provided to a Medicaid recipient who is enrolled in an HMO only if the service is included in the contract that the HMO has with the FQHC. Reconciling the HMO contracts with FQHC requirements may become an issue.

Wisconsin uses a modified RHC cost report. The state assumed that national regulations for FQHCs would be fairly similar to the established RHC cost-based methodology, so that using a modified RHC cost report form would make the transition to the federal regulations easier. Some definition problems arose, such as the definition of an encounter, which were worked out to the satisfaction of the Medicaid Program and the FQHCs.

An audited cost report is due to Medicaid within 120 days of the end of a center's fiscal year and is used to establish the FQHC's reimbursement for 100 percent of costs. During the first year's implementation, Medicaid was willing to accept a cost report for more or less than 12 months, that is, for the period beginning April 1, 1990 and ending with the end of a center's first fiscal year. Thereafter, the fiscal year will end in 12-month periods beginning on the first day after the end of the first cost report. After the acceptance, review, and approval of the cost reports, any unpaid costs will be paid to the FQHC. The Medicaid program does not specify a time period for the review and reconciliation process.

Recoupment policies have not been articulated in the state's final FQHC policies. However, Medicaid officials report that they are flexible in handling recoupment of costs from the FQHCs. Options include total repayment within 60 days of notification, reductions in subsequent fee-for-service payments, or reduction of quarterly payments. Because Medicaid aims to recoup overpayments within six months, monthly installments of payments is also an option.

All FQHCs have filed cost reports; most have elected to file quarterly reports, and a few have filed year-end cost reports. At the time of the site visit, no reconciliations had been completed. None of the seven FQHCs chose the flat-fee option, which obviates the filing of a cost report.

2. **Financial Impact of FQHC Reimbursement**

FQHC reimbursement was generally recognized by respondents as a fair program that does not make Wisconsin "better or worse off than anyone else" in terms of reimbursement policies or levels. The final cost settlements for the FQHCs have not yet been determined, but the program's incremental cost to the Medicaid budget in the first year was estimated at around $7 million. At the time of the Wisconsin site visits, the Medicaid General Purpose Revenue Fund had an $86 million deficit, and the re-estimation of Medicaid costs for the next biennium were being debated in the state legislature. However, although no reduction in FQHC payments was being considered.

3. **State Implementation Issues**

Wisconsin Medicaid agency officials reported several problems with implementing the FQHC program. The lack of direction from HCFA was specifically noted as a factor that complicated all phases of the implementation process.

a. Lack of Federal Direction

FQHC reimbursement was considered a "challenge to implement" and that "could have been made easier with direction from the Public Health Service." When Wisconsin realized that it was not going to receive substantive direction from the federal government, Medicaid officials decided to move promptly. Medicaid staff believed that they lacked federal sources to answer questions related to FQHC program structure, "gray-area" services, and accounting.

b. Time-Consuming Process

According one Medicaid official, "on the surface, cost-based reimbursement sounds great because Medicaid money is being used to provide services to those persons most in need; however, the reality of FQHC is that it is a very time-consuming process." Medicaid staff believe that the absence of federal guidelines for use in problem resolution partially explains why the agency, its auditors, and the centers find the FQHC cost report audits to be time consuming.

One Medicaid official asked the Wisconsin site visit team to relay to the Public Health Service a suggestion that it might "categorize community health centers based on the amount and types of services provided and come up with a reasonable dollar amount close to cost for each category."

c. **Absence of Rules on HMO-Contracted Services**

The inclusion of HMO-contracted services in the FQHC payment methodology was a major issue for Milwaukee FQHCs, which serve Medicaid recipients who are assigned to them as part of the state's Medicaid HMO-waiver program. OBRA-89 had not clarified whether the state should include CHCs that contract with HMOs; after the state agreed to include these CHCs, OBRA-90 made their inclusion mandatory. The Medicaid agency was interested in continuing to support HMO waiver program, but it did not want the HMOs to be the intermediary between Medicaid and the FQHCs. Medicaid designed its reporting system so that the Medicaid agency would deal directly with the FQHCs on the cost report; as a cross-check, the HMOs are required to report how much they pay the FQHCs. An FQHC continues to receive the reimbursement specified in its contract with the HMO.

d. Rate Methodology Issues

Several issues arose as the methodology was being developed. For the most part, they were resolved through meetings attended by state officials, representatives of the Wisconsin PCA and representatives of the FQHCs. A few examples include decisions to adopt a modified version of the

RHC cost report; not to include a cap on the encounter rate; not include productivity screens; include a ceiling of 30 percent on overhead costs; and require independent CPA audits of FQHCs.

G. CONCLUSIONS

We chose the six states that were the subjects of site visits for this study primarily because they were among the most experienced with cost-based reimbursement to FQHCs, in other words, they were among the first to have a HCFA-approved FQHC Medicaid plan, and they were the first to begin payments to the FQHCs under this new method. Therefore, they have been among the first to demonstrate the strengths and weaknesses of the program.

1. Strengths

Among the strengths identified during the site visits were:

- The availability of cost-reporting forms used for other payment programs, in particular FFHC and RHC cost report forms, expedited the implementation process. Because of these two programs at least some FQHCs in each of the states were familiar with cost-reporting methods. With technical assistance from state PCAs, these FQHCs were able to work with the state Medicaid agencies to develop some of the procedural and more technical aspects of this type of reimbursement.

- One-half of the state Medicaid agencies interviewed for this study volunteered that FQHC reimbursement offered an opportunity to expand services for Medicaid recipients and to fulfill the agency mission of providing access to services for underserved populations, especially in inner cities and rural areas. Although we do not yet have data to demonstrate that FQHCs have increased the number of Medicaid patients, anecdotal information from several of the sites indicate that efforts are being made to expand Medicaid enrollments.

- Some states viewed the increased payments to the FQHCs as a small percentage of their overall Medicaid budgets (usually a fraction of 1% of the total budget) and, despite the fiscal problems of many of them, did not consider FQHC reimbursement a major financial burden.

- Generally, prior to FQHC implementation, state Medicaid agencies were not familiar with the concepts of Section 329,330, and 340 health centers as separate or special categories of health-care providers. The FQHC implementation process was an opportunity for the state agencies to learn about the organizational, financial, and staffing structures that differentiate these sites from other Medicaid providers.

- All interviewed of the states developed the FQHC methodology through a negotiation process that included Medicaid and other state officials, representatives of the PCA, and administrators of individual CHCs. There was a generally inclusive participatory process in the development of policy and procedures.

2. **Problem Areas**

For the most part, despite their relatively long history with FQHC implementation, the six states have not yet completed full implementation of the program, as shown by a backlog of sites that have not yet completed the reconciliation process for the first year of payments. Although some weaknesses or problems with FQHC reimbursement have been identified, it is anticipated that some policies and procedures will be further refined, as the states gain additional experience. Common weaknesses of the FQHC implementation process include:

- Lack of federal regulations and guidelines, which all states considered a serious impediment to the implementation process. State policies and procedures, which include billing and cost report forms, carry the caveat that they are subject to change pending federal regulations. The states are concerned that much of the time, expense, and effort expended on the development of policies and procedures will be negated by the federal regulations.

- Lack of federal recognition of limited financial and administrative resources which are needed for FQHC implementation has led to delays and interruptions in payments to the centers. Many Medicaid budgets are victims of statewide fiscal crises and, although the incremental cost of Medicaid payments to FQHCs is low when viewed in the context of the total budget, program implementation has required the expenditures of considerable time and expense for state agencies. For example, FQHC required additional staff time for education on cost reporting principles, processing of new reports, and audits; reprogramming of computers; and renegotiation with fiscal intermediaries for FQHC data processing and payments (at an additional expense). The relatively short notice and lead time for implementation was considered unreasonable by some state Medicaid agencies.

- Few Medicaid agencies have had experience with cost-based reimbursement or a familiarity with M/CHCs, yet no information or assistance was forthcoming from federal sources that could have aided the agencies in the early stages of the program. For example, information on the FFHC and RHC programs, both of which are based on cost reimbursement, would have been useful as guidelines, as would have information on the financial and reporting requirements of Section 329, 330 and 340 programs- Information on the federally funded programs would have led to an earlier and better understanding of the federal goals for this program. The experience of those Medicaid agencies that had some familiarity with

cost-based reimbursement was derived from hospital and nursing home reimbursement methodologies.

- The proliferation of look-alike centers that qualify for FQHC status is of increasing concern to some Medicaid agencies. Nationwide, 77 look-alikes have been approved by June, 1992. Their numbers, however, have been concentrated in certain areas, including one study state--Illinois. Recent publicity through news articles in national medical newspapers, nationwide mailings to physicians, and presentations at national meetings is expected to increase the number of look-alike applications. The need for more careful scrutiny of these applications in the interpretation of qualifications was mentioned by a few informants. Indeed, the requirements are reported to be currently under review at BHCDA.

III. DESCRIPTION OF STUDY SITES

Nine centers were chosen as sites for the case studies according to the criteria described in Chapter I. This chapter briefly reviews these criteria, describes the key characteristics of the nine centers, and provides a general profile of the sites.

A. REVIEW OF SELECTION CRITERIA AND PROCESS

The sites for this study were chosen by design in order to assess programs and projects that had already received FQHC Medicaid payments and had active plans to use these new revenues. By carefully inquiring into the priorities and decision making processes of centers, the study was designed to describe *thepotential* of the FQHC system to expand the service capacity of C/MHCs. This goal drove the selection of centers to include those that had as much experience with FQHC cost-based reimbursement as possible and that had already made changes or were planning expansions in staffing, scope of services, or buildings as a result of FQHC payment modifications.

Since the FQHC payment system has not been implemented evenly across states, the selection of sites required a multi-stage process to identify those centers with sufficient use of FQHC experience and the reputation for making use of the new revenue. As described in Chapter I, the selection process was designed in consultation with the project officer from the Bureau of Health Care Delivery and Assistance (BHCDA), and the final sites were chosen from a list of candidates recommended to the project officer. The final list is shown in Table 111.1.

B. KEY CHARACTERISTICS OF THE STUDY CENTERS

The centers were chosen to represent ranges of size, location, and proportion of Medicaid patient revenues. These characteristics are summarized in Table 111.2. Note that with only six study

TABLE III.1

SITES SELECTED FOR CASE STUDIES

Illinois

Cairo - Community Health and Emergency Services, Inc.
Centreville - Southern Illinois Health Care Foundation

Maryland

Baltimore - People's Community Health Center, Inc.

Rhode Island

Providence - Providence Ambulatory Health Care Foundation, Inc.

Texas

Eagle Pass - United Medical Centers, Inc.
Dallas - Martin Luther Ring, Jr. Family Clinic, Inc.

Virginia

Axton - Sandy River Medical Center

Wisconsin

Minong - North Woods Medical Cooperative
Milwaukee - Sixteenth Street CHC (H.O.P.E., Inc.)

TABLE iII.2

CHARACTERISTICS OF STUDY SITES

Study Centers	PHS Region	Urban/ Rural	Year of First 330 Grant Support	Number of Clinic Sites	1990 Total Medical Users*	Medicaid Revenue as % of Total Revenue*
Illinois						
Cairo	V	Rural	1974	**2**	**5,795**	**32.9%** (high)
Centreville	V	Urban	1986	2	3,620	26.7% (high)
Maryland						
Baltimore	III	Urban	1990 (fully qualified "look-alike" status)	1	NA	18.4% (medium)
Rhode Island						
Providence	I	Urban	1967	**5**	**22,776**	**14.0%** (medium)
Texas						
Eagle Pass	**VI**	Rural	1978	**3**	**13,708**	**4.5% (low)**
Dallas	**VI**	Urban	1986	1	**7,095**	**7.7%** (low)
Virginia						
Axton, VA	III	Rural	1986 as satellite site; 1990 as freestanding site	1	2,528	7.6% (low)
Wisconsin						
Milwaukee	V	Urban	1984	1	6,229	10.4% (medium)
Minong	V	Rural	1980	3	3,658	5.2% (low)

*Derived from 1990 BCRR data, Sheps Center for Health Services Research, University of North Carolina at Chapel Hill; information for the "look-alike" site was provided by health center staff.

states regional representation is limited. The study does not include C/MHCs on the West Coast, and the southern states in Region IV, which have the greatest number of C/MHC programs, unfortunately did not have sufficient experience with FQHC implementation to meet the selection criteria. The "look-alike" that was chosen for this study (People's Community Health Center in Baltimore) was the first fully qualified FQHC look-alike approved by the BHCDA. The following sections describe the key characteristics of the study sites, including history, missions and plans, structures, caseloads and revenues, facilities and services, staffing and user characteristics.

1. History

The selected centers include new and old C/MHCs, centers that had grown from earlier, community roots, and those that were created as community health centers without any previous organizational history. The newest health center opened in 1986 (Axton). One of the study sites (Minong) began as a rural health cooperative in 1976; in 1980, it applied for and received CHC funding. Two others were funded as CHCs after developing under other initiatives. One of the two (Eagle Pass) grew out of an experimental child health clinic supported by the American Academy of Pediatrics in 1973. It began receiving CHC funds in 1978. Another started in 1974 as an outpatient center attached to a hospital (Cairo). One site began in 1978 as part of a proposed network of CHCs (Dallas). However, when the network lost federal support, the center was funded and has operated on its own since 1986. One site (Baltimore) opened in 1970 as a free clinic without federal support and has continued to operate as an independent center receiving local, state, and foundation support. It has previously been turned down for funding but plans to apply again. Another (Milwaukee) began in 1970 as a joint hospital-medical school project; it began receiving federal CHC funds in 1984. The oldest was formed in 1967 as a free clinic that was funded as an Office of Economic Opportunity (OEO) Neighborhood Health Center and subsequently was funded by the Public Health Service as a CHC (Providence).

The centers represent a range of initiatives that have created the cohort of CHCs in this study. They were developed in response to clear perceptions of a need to provide health care services to poor and underserved people. The centers in rural areas were more likely to have developed to replace practitioners who left the area, as was clearly the case in one center located in an urban community that had been severely hit by economic relocation and the decay of local industry (Centreville). The health-care infrastructure for that community was in a severe state of decline prior to the opening and eventual expansion of the health center.

The centers also reflect the range of organizational change that has occurred in the governance and interorganizational relationships of CHCs. The boards of two centers (Dallas, Milwaukee) have changed significantly to reflect changes in the community groups governing the programs. Other programs have essentially maintained their original missions and continue to represent approximately the same community populations (Baltimore, Providence, and Minong). The programs have been organizationally functional parts of hospitals or components of community organizations with general service missions, one has functioned essentially independently as a CHC. The centers have also received funding from a wide variety of sources, including foundations, local governments, state agencies and programs, the WIC program, Farmer's Home Administration, Title XX, Urban Block Grants, religious organizations, specialty associations, and one or two wealthy individuals who generously support health centers. All of the centers actively pursue funding beyond the 330/329 grants, although some have been more successful at obtaining supplemental grants than others.

The historical development of the health centers is not always reflected in their current missions and organizational structure. One activist project, which had been tied to a single urban population group, has focused on broader service delivery (Milwaukee); projects having a single clinical focus have become comprehensive health centers (Eagle Pass).

The duration of a health center's existence seems to bear little relationship to a program's ability to plan and implement the FQHC process. Such factors as the continuity of staff have more to do with the ability of the health centers to adjust than does their heritage.

2. **Missions and Plans**

All nine sites are committed to providing health care for indigents in their communities, although the proportion of uninsured in their patient loads and their potential for developing third party income sources differ. The inception of the FQHC program caused once site (Centreville) to emphasize drawing "paying" patients, with the FQHC income allowing the program to anticipate providing more indigent care; however, that was the exception.

Several centers consciously attempt to develop training programs for their staff and to improve the skills of indigenous workers to assist in the economic development of the community. One center sees part of its role as that of recruiting doctors to the local community and integrating them into the mainstream medical community in nearby towns (Axton). Two other centers are attempting to lead in the organization and coordination of health services for their immediate regions and are expanding their services to include a range of medical care beyond the normal primary care and preventive services found in a C/MHC (Centreville and Cairo).

3. Structures

The study centers include both multisite and single-site programs. Some belong to networks or joint projects or operate under umbrella agencies. Four centers operate as independent, single-site organizations (Dallas, Baltimore, Axton, and Milwaukee), although one maintains a part-time school health program. Three centers have recently developed new satellite sites (Cairo, Centreville, and Minong). Another center has long operated three clinic sites in three rural counties (Eagle Pass). One center maintains services in a homeless site and provides other off-site services, and one center comprises five delivery sites in a single urban city (Providence).

4. Caseloads and Revenues

The caseloads of the centers reflect their size differences. In 1990, the number of users ranged from **3,620** to **22,776** patients, and the number of encounters varied from 10,500 to 192,314. The changes in utilization generally reflect a pattern of steady growth in the centers. Since 1985, the number of users of one center has increased from 3,000 to 7,000. Almost all of the variation has been related to the changes in the number and mix of providers. Table III.3 shows the total number of encounters for each site and the proportion of encounters by type of provider. Encounters with primary care physicians range from almost 89 to less than 30 percent of all encounters. Centers with the lowest proportions of such encounters tend to have a large social services staffing component (Eagle Pass and Providence). Encounters with mid-level practitioners range from less than 2 to almost 19 percent of total encounters. Two of the three centers with the highest proportion of mid-level encounters are located in rural areas (Cairo and Axton). Only one center (Minong), located in a rural area, did not have a mid-level practitioner on staff in 1990.

As Table III.4 shows, the revenue structures of the centers vary considerably among the eight federally supported CHCs and the single look-alike clinic. The size of the sites, as measured by total revenues, ranges from about $360,000 to about $6.2 million. In 1990, the proportion of total revenues from direct payments by patients varied between 2 to 22 percent. The proportion from Section 330 grants ranged from 71 to 43 percent, and the proportion from Medicaid varied from a low of **5** to a high of 33 percent. Two of the centers receive Section 329 funds, although other centers treat migrants under other funding arrangements. Two of the centers have contracts to treat Native Americans through the Indian Health Services or tribal councils. One of the centers participates in a Medicaid health maintenance program (HMO) waiver program unique to its urban area; the HMO restricts the number of new Medicaid patients that are available to the center. Another center is affiliated with a local HMO; 64 percent of the centers 1990 revenue came from the HMO, mostly from Medicaid HMO patients. Several of the centers are involved in some form

TABLE III.3

1990 ENCOUNTERS AT STUDY CENTERS
(Percent of Total Encounters)

Study Centers	Total Encounters	Primaty Care Physician Encounters	Mid-Level Practitioner Encounters	Nurse (Medical) Encounters
Illinois				
Cairo	37,660	16,396 (43.5%)	3,519 (9.3%)	0
Centreville	18,162	15,706 (86.5%)	1,043 (5.7%)	727 (4.0%)
Maryland				
Baltimore	NA	NA	NA	NA
Rhode Island				
Providence	192,314	56,208 (29.2%)	6,059 (3.2%)	20,687 (10.8%)
Texas				
Eagle Pass	105,152	41,796 (39.7%)	1,529 (1.5%)	16,754 (15.9%)
Dallas	45,837	14,873 (32.4%)	8,564 (18.7%)	7,797 (17.0%)
Virginia				
Axton	10,625	8,372 (78.8%)	1,476 (13.9%)	777 (7.3%)
Wisconsin				
Milwaukee	52,095	19,536 (37.5%)	1,854 (3.6%)	2,860 (5.5%)
Minong	10,527	9,345 (88.8%)	0	1,151 (10.9%)

SOURCE: All information derived from 1990 BCRR data, Sheps Center for Health Services Research, University of North Carolina at Chapel Hill; BCRR data for the "look-alike" site are not available.

TABLE III.4

1990 MAJOR REVENUE SOURCES OF STUDY CENTERS:
PERCENT OF TOTAL REVENUE

Studv Centers	Total Revenue	Percent Medicaid	Percent 330 Grant	Percent Patient Collection	Percent Other
Illinois					
Cairo	$1,937,300	32.9	43.6	10.4	13.1
Centreville	$1,286,349	26.7	62.9	2.0	8.4
Maryland					
Baltimore	$357,042	18.4	NA	9.1	72.6
Rhode Island					
Providence	$6,175,494	14.0	44.3	2.8	38.9
Texas					
Eagle Pass	$4,217,037	4.5	50.4	11.3	33.8
Dallas	$1,745,723	8.1	71.2	9.3	11.4
Virginia					
Axton	$570,801	8.0	53.4	22.0	16.6
Wisconsin					
Milwaukee	$2,075,574	11.5	52.0	1.9	34.6
Minong	$664,308	5.2	42.9	21.6	30.3

SOURCE: All information derived from 1990 BCRR data, Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, with the exception of the "look-alike" site data, which was obtained directly from the center staff.

of case-management for selected populations, including perinatal programs and programs for special groups, such as diabetics and high users of health services.

5. Facilities and Services

A common characteristic of all nine study sites was their stated inability to expand staffing and services due to physical space limitations in their current facilities. Four centers have remained in their original buildings (Eagle Pass, Baltimore, Sandy River, and Providence); two of the four were incorporated as nonprofit health centers in the early to mid-1970s and were housed in buildings that were not designed as medical offices. Indeed, only four of the nine sites occupy space originally constructed for medical clinic purposes (Centreville, Minong, Axton, and Eagle Pass); three of these centers are also the youngest C/MHCs in the study cohort. Three centers occupy two or more floors of buildings more than 50 years old (Baltimore, Milwaukee, and Cairo); these centers considered the age, construction materials, and multi-story arrangements of their buildings as impediments to vertical computer linkages and optimal patient tracking. At the time of our site visits, in early 1992, one of the three centers (Cairo) had a new clinic under construction and was due to move to the new site within six months. In addition,two centers had satellite sites in development or under construction (Cairo and Centreville). One site, which is currently operating at capacity, is expected to lose administrative office and dental clinic space to a bridge that is under construction.

Several of the sites occupy buildings that are adjacent to or house other health and social service organizations. One rural center was built with Community Development Block Grant funding; its building is also occupied by a private practice physical therapist, a local mental health agency provider, and county health department staff. One urban site is located in a city-owned multipurpose complex that includes legal services, social services, a public library, a child care center, and a recreation center. A third center, which is committed to promoting coordinated services among the community's health and social services providers, shares a parking lot with the adjacent community hospital. In June of 1992, this center opened a satellite site adjacent to the local health department.

The study sites provide a range of services, from a focus on basic primary care services provided by family physicians only (Minong), to comprehensive, multi-departmental programs with obstetric services, pediatrics, adult care, WIC services, case management and social services, dentistry, transportation, pharmacy,. environmental services, and radiology.' One center is scheduled to open a new outpatient surgical service in 1992. As a comprehensive megaclinic, which includes a urologist, part-time neurologist, ophthalmologists, and an outpatient surgical department, the Cairo site eventually will provide six beds for 72-hour stays. On-site services beyond those required of Section 330 grantees include staffing of school-based clinics (Providence, Cairo, and Dallas), an STD clinic (Providence), podiatry (Cairo), HIV/AIDS services (Providence and Eagle Pass), and mental health services (Minong).

Centers that are located in ethnic minority neighborhoods have multi-lingual medical staff or provide translation services for patients, including those of Hmong, Hispanic, and Native American backgrounds. Two sites receive migrant health funds under Section 329 funding, and two have contracts to treat Native Americans through the Bureau of Indian Health Services or tribal council arrangements.

6. **Medical Provider Staffing**

The physician staffing of the sites generally reflects the primary care mission of the community health centers. An exception is the medical director of one center, a general surgeon whose one goal is shared by the center--to care for emergency patients at a new, expanded location. Many centers have had recent physician vacancies, yet five were fully staffed at the time of the site visits (Axton, Baltimore, Cairo, Centrevilles and Dallas). The physicians on staff included board-certified and board-eligible family physicians, obstetricians/gynecologists, pediatricians, internists, and general practice physicians.

One of the programs employed an osteopathic physician. Only one program did not have a non-physician primary care provider, such as a physician assistant, nurse practitioner, or nurse midwife, on staff.

The centers employed or contracted with 2.0 to 15.0 full-time equivalent (FTE) physicians. One site listed 17 physician slots (Providence), which were supplemented by medical students and residents. Another site was recently designated an AHEC regional teaching center and expects as many as seven students from various disciplines to rotate through each year Another site hosts as many as 11 residents from an affiliated hospital program at any one time. The manner in which the trainees' services are accounted for in the cost reports varies among the centers and by type of trainees, depending on the type and duration of service delivery.

The centers employed physicians directly, or engaged them in contractual arrangements. The centers also used a variety of arrangements to contract with specialist physicians for clinics and **services.** Formal agreements were made between individual centers and hospitals for specialty coverage, or individual physicians were contracted for specific services for specific times. Most often, these services included obstetrics and gynecology, with ophthalmology and urology being contracted for in single clinics.

All but one of the centers has in the past used the National Health Service Corps to supplement staff. The single site that has not done so has been ineligible under BHCDA standards and is experiencing substantial recruitment problems.

The medical staffing levels, shown in Table 111.5, are based on BCRR data. For centers employing mid-level practitioners (physician assistants, nurse practitioners, nurse midwives), the proportion of mid-level FTEs to total medical FTEs ranged from 3.5 to nearly 13 percent. Two of the three centers with the highest proportion of mid-levels among total medical FTEs were located

TABLE 111.5

1990 FTE SELECTED STAFFING OF STUDY SITES

Study Centers	Total FTEs	Total Medical FTEs	Primary Care FTEs	Mid-Level Practitioner FTEs	Nurse FTEs
Illinois					
Cairo	40.6	9.9	3.1	.7	**3.6**
Centreville	23.4	11.8	3.9	.6	**3.6**
Maryland					
Baltimore	**NA**	NA	2.75	**1.5**	3.0
Rhode Island					
Providence	152.4	62.1	11.3	**2.8**	**22.5**
Texas					
Eagle Pass	111.5	**26.8**	**7.9**	1.0	11.0
Dallas	38.3	**13.8**	**3.6**	2.8	2.4
Virginia					
Axton	10.6	6.3	1.5	**0.8**	2.4
Wisconsin					
Milwaukee	51.8	14.4	5.1	0.5	**4.8**
Minong	10.1	4.9	2.2	0	**1.0**

SOURCE: All information derived from 1990 BCRR data, Sheps Center for Health Services Research, University of North Carolina at Chapel Hill; data for the "look-alike" site were obtained from the center's staff and was for 1991.

in rural areas, which is consistent with the information in the previous section on primary care encounters. The proportion of total medical FTEs to total FTEs ranged from 24 to about 60 percent.

7. User Characteristics

The users of the centers reflect in part the special characteristics of the service areas. The communities are uniformly poorer than the nation as a whole and include substantial minority populations. With the exception of Minong (a rural center in the upper midwest), the non-white population of the centers' service areas is over 15 percent and runs as high as 71 percent. Hispanics make up a majority of one service area's population (Milwaukee) and shares of 16, 22, and 40 percent in three highest other clinics. African-Americans are in the majority in the service areas of three other clinics (Dallas, Centreville, and Baltimore) and comprise, respectively, 34, 30 and 19 percent of the population in three others. The users in these communities do not directly reflect the local racial and economic demographics of the service areas; the users are more often minorities and poorer that those in the surrounding service areas. For example, in one center's community, the population is 64 percent white, but 64 percent of the users of the center are African-American. In the same community, 55 percent of the population is below the poverty level, whereas 70 percent of the users fall below the poverty level.

The insurance profiles of center patients reflect the economic circumstances of their service areas (Table III.6). The percentage of users with Medicaid coverage ranges from 16 to 75 percent. The rural site that had the lowest proportion of Medicaid users also had the highest proportions of users covered by Medicare (20 percent) and by other third-party insurance (46 percent). In general, private insurance coverage of center patients is obtained through individually purchased policies, rather than through employers, has high co-payments and deductibles (for example, $500 to $1,000 per person per year) and is limited to a narrow scope of covered services. Between 1990 and 1991, the percentage of users in this rural community with household incomes below the poverty level increased from 24 to 41 percent. For the urban site reporting 31 percent of users with third-party coverage,

TABLE III.6

INSURANCE PROFILE OF STUDY SITE USERS*

Site	Medicaid	Medicare	Other Third-Party Insurance	No Insurance
Illinois				
Cairo	56%	13%	31%	NA
Cen treville	75%	4%	0%	21%
Maryland				
Baltimore	32%	5%	23%	40%
Rhode Island				
Providence	38%	3%	17%	42%
Texas				
Eagle Pass	20%	10%	10%	60%
Dallas	30%	5%	1%	64%
Virginia				
Axton	27%	16%	23%	34%
Wisconsin				
Milwaukee	42%	3%	23%	32%
Minong	16%	20%	46%	18%

*Latest period for which data are available; varies with the individual centers.

70 percent of the population is at or below the poverty level; its 1991 unemployment rate reached nearly 18 percent.

Overall, the percentage of the user populations of the nine study sites who relied on public insurance programs ranged from 30 to 79 percent. The site with the lowest proportion of publicly insured users also had a very high percentage of users (60 percent) with no insurance coverage. The percentage of the user populations with either public insurance or no insurance ranges from 54 to 100 percent.

C. GENERAL PROFILE OF SITES

The nine sites that were chosen as subjects of the case studies because they met predetermined criteria for location, size, proportion of Medicaid patients, and reputation for having an active program to use FQHC revenues. The sites therefore represent a wide variety of characteristics. The selected sites included five urban centers, four rural centers, and one look-alike. Four Public Health Service regions are represented. All of the sites have been in existence for at least six years; the oldest received its first Section 330 grant in 1974. The centers range in size from one operating with one site serving about 2,500 users to one with five sites serving nearly 23,000 users. Total medical staffing at the nine sites ranges from about 5 to 62 FTEs. In 1990, the year that the FQHC program was mandated to begin, the nine sites received Medicaid reimbursement that represented between 4.5 and 33 percent of their total revenues. Total revenues ranged from about $357,000 to $4.2 million. The insurance profiles of the nine sites showed that 16 and 75 percent of the site users were covered by Medicaid; private third-party insurance covered from between zero to 46 percent of site users.

This study is limited to a select group of centers that not only had a prior reputation for effective management, but were located in states in which the initial implementation of a FQHC reimbursement methodology proceeded comparatively smoothly. However, the diversity of center characteristics raises the question of whether responses to the new revenue differ according to specific center factors. The next chapter will detail the impact of the new program on the operations and plans of the centers.

IV. FQHC IMPLEMENTATION AT THE CENTER LEVEL

In principle and by legislative intent, the Federally Qualified Health Center (FQHC) legislation seeks to reinforce the long-standing mission of community health centers--to ensure access to primary care services among the low-income and vulnerable populations within their respective communities. Cost-based Medicaid payments should yield revenue increases that, over the long term, would translate into enhanced capacity to deliver service. However, FQHC implementation requires that centers first address fundamental administrative and clinical challenges to successfully achieve fiscally sound and sustainable growth.

This chapter summarizes the early-stage implementation challenges and findings based on our nine case study sites. The analysis focuses on what changes individual centers have experienced and how they have responded to the FQHC in terms of:

- Administrative issues and problems in implementation
- Initial changes in Medicaid revenue and utilization
- Management considerations and strategic planning
- Actual and planned allocation of FQHC revenues

Although the initial revenue effects of the FQHC appear substantial, they vary greatly among centers. More importantly, the difficulty in developing consistent and comparable estimates of revenue impact illustrate the data limitations under which centers have been working. Throughout the presentation, we emphasize implementation issues that are crucial for making and carrying out plans for allocating anticipated FQHC revenues. In addition, we profile individual centers' FQHC revenue allocation plans and present a typology for categorizing centers' initial use of FQHC revenues.

A. ADMINISTRATIVE ISSUES AND PROBLEMS IN IMPLEMENTATION

Any form of cost-based reimbursement is new to most centers. With their primary revenue sources being grants and, to a lesser extent, Medicaid's prescribed schedule of fee-for-service payments, application of cost-accounting principles was a challenge for some of our study centers.

The pre-implementation phase, including decisions by the centers to seek FQHC status and filing of first-year cost reports, was a relatively smooth process for most of the study centers. However, the centers did experience administrative start-up problems. Furthermore, early implementation centers are aware that federal and state regulations may change in the future.

Advance pre-implementation training efforts, sponsored by the state primary care associations (PCAs), were generally considered valuable. The state PCAs and the National Association of Community Health Centers (NACHC) attempted to facilitate timely implementation by sponsoring technical-assistance workshops on cost-accounting issues, data requirements, and cost-report preparation. All of the study centers participated in these seminars and training sessions. Some centers (for example, Providence) had prior experience in preparing cost reports for the Federally Funded Health Center (FFHC) or Rural Health Clinic (RHC) programs and thus had the in-house expertise and data necessary for the initial filing.

These PCA and NACHC efforts, notwithstanding, some centers observed that available training and guidance were less than adequate. For example, Centreville stated that the state provided inadequate instructions for completing the cost reports. Other centers indicated that cost accounting required additional commitment of resources to obtain necessary data, as well as subsequent investments to up-grade their data management and accounting systems (for example, Cairo and Minong.

Respondents felt that any pre-implementation problems at the center level were partly due to the lack of clear direction at the federal level. As discussed in Chapter II, the Health Care Financing Administration (HCFA) has not issued FQHC-Medicaid implementation regulations. As a result the

implementation burden shifted to the states. The centers, in turn, relied primarily on their state PCAs to negotiate the structure and content of FQHC cost reports, allowable services, and related payment reconciliation rules. Some PCAs viewed these negotiations as potentially leading to interim decisions, with outstanding issues to be addressed subsequent to issuance of HCFA regulations. For example, Rhode Island's decision to adopt the existing federal FFHC cost report with minimal modifications remains controversial and problematic from the point of view of the Providence center's staff. (At particular issue is the allocation of costs for services not specifically included in the FFHC approach.)

B. INITIAL CHANGES IN MEDICAID REVENUE AND UTILIZATION

The substantial revenue increases since 1989 are not solely due to implementation of FQHC. Some of these centers are also serving an increasing number of Medicaid enrollees. The pre-FQHC baseline year (CY 1989) is prior to some of the recent Medicaid eligibility expansions. In the following sections, we will review the experience of the nine study centers, first describing overall changes in Medicaid revenue and then discussing its two components-- 1) increases in FQHC payment rates per encounter and 2) shifts in utilization. Since most centers have experienced considerable differences between the amounts billed to Medicaid and payments actually received, a fourth section will discuss delays in reimbursement.

1. Changes in Medicaid Revenue

Although FQHC implementation in these states is still in its early phases, Medicaid revenues to the nine centers appear to have increased substantially. Table IV.1 presents the currently-available data on pre-and post-FQHC Medicaid revenues, by study site.' Note that the table shows two different measures of post-FQHC revenues:

- *Estimated or reported* ***billables*** are the total amount Medicaid is expected to pay for services rendered during a 12-month period. Billables are estimated based on the

center's established cost-based payment rate, whether or not revenues were actually received during that year.

- ***Actual or estimated revenues*** include all funds which Medicaid paid to the center during the 12-month period. Actual revenues include payments for services rendered during that year and retroactive cost-settlements applicable to a prior year.

By either measure, the joint revenue effects of the Medicaid expansions and the FQHC program have been significant. As Table IV.1 indicates, ***virtually all sites should see revenues at least double*** after cost settlements are completed and payments for all services rendered in 1991 are made. Three sites expect to receive more than $1 million for services in 1991; in comparison, these centers received Medicaid revenues ranging from slightly over $100,000 to $475,000 in 1989. As the numerous notes to the table indicate, the increases are often estimates.

While total billable revenues are impressive, the ***actual*** revenues received during the first FQHC year were typically considerably lower. By the time of our visits, only two sites indicated that they had received their full FQHC payments for 1991 (Baltimore, Axton). Two others (Eagle Pass and Dallas) had filed cost reports, but state audits had not been finished. Medicaid delays in issuing payment for agreed upon costs explain the short-fall in actual payments at several study sites. In the extreme case of Milwaukee, actual Medicaid revenue received in 1991 was less than the baseline year despite a "paper" increase of over 50 percent. As noted previously, FQHC Medicaid payment lags are a problem in several early implementation states. Similarly, some states have been slow in conducting (or commencing) audits necessary for reconciliation (Maryland and Wisconsin). Thus, a complete analysis of the revenue impact for several study sites will not be possible until first year reconciliations occur.

2. Changes in FQHC Payment Rates

Any assessment of FQHC needs to examine Medicaid payment rates as well as total Medicaid revenues. Unfortunately, simple pre-post comparisons of payment rates are not necessarily very

TABLE IV.1

MEDICAID REVENUES -- PRE-FQHC AND FIRST YEAR FQHC

Study Sites	Pre-FQHC Revenues (CY 1989 BCRR)	FQHC Medicaid Revenues (Estimated or Reported Billables)	FQHC Medicaid Revenues (1991 Actual or Estimated Payments)	Percent Change in Revenues	
				Billables	Payments
Illinois					
Cairo	$465,882	$1,280,240 [a]	$800,000 [b]	75	72
Centreville	$288,556	$737,814 [c]	$646,348 [d]	156	124
Maryland					
Baltimore	$65,632 [e]	$125,315 [f]	$125,315 [g]	91	91
Rhode Island					
Providence	$475,245	$1,321,385 [h]	$964,611 [i]	178	103
Texas					
Dallas	$84,994	$574,737 [j]	3373,428 [k]	576	339
Eagle Pass	$114,553	$1,035,645 [l]	$307,517 [m]	804	168
Virginia					
Axton	$39,377 [n]	$98,233 [o]	$98,233 [p]	149	149
Wisconsin					
Milwaukee	$444,389	$700,000 [q]	$352,400 [r]	57	-20.7
Minong	$39,391	$139,339 [s]	$90,303 [t]	254	129

NOTES:

[a] Based on 1st year FQHC rate x reported encounters, FY 1990.
[b] Based on CY 1991, estimated.
[c] Based on 1st year FQHC rate x reported encounters, FY 1991.
[d] Based on CY 1991, BCRR data.
[e] 1990 pre-FQHC Medicaid revenues, as reported by center.
'Center data for 1991, includes retroactive FQHC payment for 1990.
[g] Center data; reconciliation has not yet occurred.
[h] Center data for 1991, estimated.
'Based on enter reported data, applying ratio of total actual FQHC payments to aggregate billables for April 1990 through February 1992.
[j] Based on cost report tiled in 1992 for 1991.
[k] Center data, includes cost settlement applicable to 1990.
'Based on cost report tiled in March, 1992 for CY 1991.
[m] Covers center fiscal year 7/90-6/91; includes 1990 reconciliation paid in 1991.
"Reported by center; previously a satellite clinic without a separate BCRR # in 1989.
[o] Center data for 1991, annualized from 11 months.
[p] Center has received FQHC payment for 1991 Medicaid billables.
[q] Based on 1st year FQHC rate x reported encounters, 11 months of 1991.
'Based on CY 1991, estimated.
*Based on 1st year FQHC rate x reported encounters, FY 1991.
'Based on CY 1991, BCRR data.

meaningful. Table IV.2 provides data on usual Medicaid payment rates prior to FQHC compared with the cost-based rates established for the study centers. This table shows very sizable increases for some centers (e.g. Centreville, Baltimore, Eagle Pass, Axton) and significant, although lower, changes in the other centers. The percentage increases often tell us more about the prevailing level of payment prior to FQHC than about differences in the centers in FQHC rates.

A comparison of payment rates before and after FQHC raises numerous measurement problems. Simply stated, FQHC has dramatically changed both the unit of service for which Medicaid payment rates are set, as well as the payment rate itself. For example, the content of an "encounter" or "visit" has changed: FQHC is an all-inclusive encounter rate for a package of primary care services, and as such covers services and procedures previously billed separately. Pre-FQHC payment methodologies, and thus the definition of a unit for billing purposes (e.g., encounters) varied significantly among the these centers.

- One center was paid on a cost basis for its core medical services under Rural Health Clinic Act (Cairo).
- One center received payment on a capitation basis for a visit (Milwaukee).
- Four centers were paid on a fee-for-service basis, using Medicaid's standard physician payment schedule. The fee shown in the table is the "office visit for an established patient" (Axton, Centreville, Dallas, Eagle Pass).
- Two centers received a special clinic visit payment (Baltimore, Providence).

As expected, the clinic visit payment rates are higher than the office visit payments since the latter does not include various tests and services that would be billed and reimbursed separately under fee-for-service Medicaid. Our Illinois sites provide an example of the magnitude of the differential between a state's fee-for-service and clinic rates. Cairo's Rural Health Clinic rate (subject to the federal RHC cap) was more than double the payment received by Centrevilie. For centers paid pre-FQHC on a fee-for-service method, the Medicaid payment for an office visit also reflects the state's

TABLE IV.2

MEDICAID PAYMENT RATES--PRE-FQHC AND FQHC

Study Sites	Pre-FQHC Medicaid Payment Rate	FQHC Medicaid Payment Rate (1991)	Percent Increase
Illinois			
Cairo	$44.00[a]	$65.00	48
Centerville	$18.75[b]	$67.97	263
Maryland			
Baltimore	$21.00[c]	$74.66	355
Rhode Island			
Providence	$24.00[d]	$62.00	158
Texas			
Dallas	$14.64[b]	$33.97[f]	132'
Eagle Pass	$14.64[b]	$74.41'	408[f]
Virginia			
Axton	$20.00[b]	$59.07[g]	295[g]
Wisconsin			
Milwaukee	$32.33[e]	$75.00	133
Minong	$44.83	$77.80	74

NOTES: [a]Rural Health Clinic rate.

[b]Medicaid payment for "intermediate physician office visit for established patient."

[c]Center's estimate for clinic visit.

[d]Medicaid payment for a clinic visit.

[e]Based on Milwaukee's negotiated Medicaid HMO capitation rate.

'Based on an analysis of cost report data, 1991 pre-FQHC payments in Texas would have been $14.50 per encounter in Dallas and $27.22 in Eagle Pass. Using the same definition of an "encounter," the FQHC reimbursement would increase to $47.75 and $103.08 respectively. These amount to increases of 229 and 278 percent. The differences of these estimates from the figures in the table are due to differences in the services included in the definition of an "encounter".

[g]Based on cost report data, 1991 pre-FQHC payments in the Virginia center would have been $27.54 per encounter using the same definition of encounter. The FQHC rate would be $59.07, or an increase of 114 percent.

relative "generosity" in setting its fee schedule for all physician services. The lowest pre-FQHC rate is in Texas (Eagle Pass, Dallas), with somewhat higher rates in Illinois (Centreville) and Virginia (Axton).

Similarly, in interpreting FQHC payment rates, care must be taken not to treat the figures as comparable measures of cost. The data in Table IV.2 indicate a range of cost-based rates for the first year from $33.97 (Dallas) to $77.00 (Minong), but these rates must be interpreted in light of each state's methodology. In higher cost centers, caps and screens are likely to affect the level of the rate. For example, Baltimore's FQHC payment of $74.66 is substantially below Maryland's cap for urban centers. Providence's FQHC payment, however, is at the rate cap (FFHC cap of $62 for 1991) and below reported actual costs. Moreover, different states include different scopes of services in the all-inclusive FQHC rate. While Virginia, for example, includes all services in the rate, Texas excludes EPSDT, pharmacy and family planning. These services are billed separately, and reconciled on the cost report. Maryland has an FQHC rate limit, but does not count costs for obstetrics, radiology and outstationed eligibility workers when determining if the center has exceeded the limit.

For three sites we were able to use a different approach in order to construct comparable estimates of Medicaid reimbursement per encounter in 1991. Using cost report data and a consistent definition of an encounter, we estimated revenue per encounter with--and without--FQHC for the centers in Texas and Virginia, states which started FQHC with fee-for-service payments, and phased-in their cost-based rates. Without FQHC, the Dallas center would have received about $14.50 per encounter, and Eagle Pass would have received $27.22. With FQHC cost-based rates, the Dallas center received $47.75 and Eagle Pass received $103.08, increases of 229 percent and 278 percent respectively. At Sandy River, reimbursement per encounter was estimated to jump from $27.54 without FQHC to $59.07 (a 114 percent increase).

In short, there can be no doubt that the FQHC formula is substantially increasing payments for services to Medicaid patients. The increases do apparently vary significantly. In the two other clinics

with comparable units of measurement (Cairo, which was previously paid on an inclusive RHC encounter rate and Milwaukee, which received an HMO capitation rate) the increases in reimbursement per encounter were 48 and 74 percent, respectively.

3. **Changes in Utilization**

Higher Medicaid payments offer an financial incentive for increasing the Medicaid case-load. Unfortunately, comparable data on the change in the numbers of Medicaid patients or encounters between 1989 and 1991 are not commonly available. Administrators at three study sites indicated, however, that they have already begun or will soon develop targeted outreach efforts to increase their Medicaid population (Cairo, Centreville, Minong). One Administrator stated that FQHC clearly presents an incentive to market their services to the Medicaid population since they are "revenue neutral". Another Administrator noted that FQHC "represents an extraordinary opportunity to establish, expand and stabilize primary medical services." A third commented that a state-initiated Medicaid expansion program has led to active competition for additional Medicaid enrollees and expects the proportion of Medicaid patients to increase substantially as a result of the Medicaid expansion program (Maryland).

One facet of FQHC noted as an important device for promoting increased Medicaid enrollment was the availability of an on-site eligibility worker. While several sites already have an eligibility worker on their clinic premises, some were awaiting the completion of state rules governing this process. One administrator noted that the "eligibility worker is a key person in the center's operations; on-site enrollment is better for the patient as well as for the center." Not all centers had eligibility workers. Some centers planned to start on-site eligibility after they had completed facility expansions that would enable them. to handle the larger caseloads and set aside office space for the worker. Another administrator noted that the computer system in his current facility was not adequate for this purpose. FQHC funds will be used to update the center's computer capability.

Respondents noted that the lack of significant efforts to increase Medicaid patients was largely due to their inability to expand staffing, services, and patients based because of physical space limitations. Current capacity limitations (space and staff, for example) at most of the study sites mitigate against immediate or aggressive marketing to new patients, whether they are Medicaid or others within the community. Virtually all study site administrators indicated that they were operating at or near capacity. They also noted the opportunity presented by FQHC to finance the expansion of physical plant, establish new services, and expand existing ones. The planned expansions, however, were general and not notably targeted toward Medicaid patients.

In addition to capacity limitations, some centers perceived a conflict between intensive efforts to increase Medicaid enrollments and their traditional mission of serving the uninsured. These centers expressed concern that increasing Medicaid caseloads might alienate the traditional patient base. Two centers, for example, sought to maintain a "healthy balance" between Medicaid and low-income or uninsured families within the community (Axton, Baltimore). One administrator stated that her center would continue it's long-standing mission in serving the uninsured. Another administrator observed that it was important for the center to continue to be a full-service and accessible provider for the entire community. FQHC centers are in the process of balancing their long-standing missions to serve all low-income, vulnerable populations and leveraging the incentives afforded by FQHC.

4. **FQHC Payment Flow--Lags and Reconciliation**

During the initial implementation years, the flow of actual FQHC payments have varied considerably among the study centers. The expectation that FQHC payments would not only cover the costs of services provided to Medicaid beneficiaries but would also provide a timely and predictable revenue source has not been fully realized. One problem has been payment lags between billing and reimbursement which extend, in the extreme case, for periods of over a year (Providence,

Cairo, Centreville). A second problem has been timely reconciliations. As a result, actual FQHC revenue lags behind costs of service Medicaid patients. Most notably:

- Rhode Island centers claim that they are owed more than $2 million in FQHC payments, including a $1 million short-fall for Providence.
- Illinois' FQHC payment flow has been very irregular. Centreville's FQHC payment lag has been running five to six months, with outstanding claims estimated at $700,000.

As noted in Chapter II, some states (Maryland, Virginia, Wisconsin) have been slow to conduct audits of center cost reports and begin the reconciliation process. Timely reconciliations involve substantial revenues for some centers. This is most clearly demonstrated in Texas, with the first-year reconciliation settlements having channelled an additional $3.2 million to the state's qualifying FQHC centers.

In three study sites, interim FQHC payment policies were established to address concerns about the direction and potential level of reconciliation settlements. Milwaukee voluntarily accepted a 15 percent withholding, pending reconciliation to insure against possible payback. The Texas centers chose to accept 80 percent of billed charges, rather than 100 percent, during the initial phases of implementation_

Although payment lags do not necessarily suggest future trends in FQHC fiscal flow, this pattern has short-term and potentially longer-term implications for individual centers. First, over the near-term, some centers may be unable to meet budgeted financial obligations. A predictable FQHC payment flow is critical for the responsible management of center operations. This is particularly the case for centers that have hired additional staff in order to meet increased Medicaid demand resulting from Medicaid's eligibility expansions for pregnant women and children. Providence, for example, indicated that it may be necessary to obtain advances from its grant in order to meet its payroll. Others indicated that they are operating at the margin and periodically face decisions to temporarily

lay-off employees or defer cost-of-living increases when unable to meet their payrolls (for example, Axton, Baltimore).

A second effect of erratic or less-than-predictable revenue flows on centers is a prudent reluctance to increase, build, or enhance delivery-system capacity. Accustomed to living within a relatively fixed budget, heavily weighted by grants, many centers appear to be inherently conservative in making decisions to expand service capacity that is not fully covered by predictable cash flow. Overall, this attitude might be considered a prudent and sound fiscal management strategy. However, the anticipated level of expansion activity to promote access among the target populations has been dampened by uneven or unpredictable FQHC payments. Furthermore, centers are becoming skeptical about the longer-term flow and level of FQHC payments.

Finally, "lumpy payments" for an extended backlog of receivables or final reconciliations make it difficult to predict how centers will use revenues. Study centers have begun to assess their respective expansion priorities. Some expansion plans (for example, staffing) require stable, ongoing, and predictable revenues, while others (for example, equipment or space) are more likely to be one-time expenditures responding to pent-up demand. Current plans may, therefore, not reflect how centers will respond to the FQHC over the longer term.

During the FQHC transition phase, lumpy-payments, including retroactive reconciliations, are perhaps to be expected and can be factored into a center's strategy for accommodating the implementation of a new cost-based reimbursement systems. One conservative approach is exemplified by Wisconsin's FQHC payment schedule (for example, voluntary percentage withholdings pending reconciliation). For other centers, the FQHC reconciliation presents a fiscal management challenge. Centers, if subject to an end-of-year reconciliation process, should plan for possible repayment. Initially, it will be very difficult to predict the direction or magnitude of reconciliation settlements. During the first years of the transition, a potential repayment liability must be factored into the center's cash-retention strategy. This concern contributed to the decision of three centers

to place some of their FQHC revenue in certificates of deposit. For these cautious centers, setting aside some funds for possible pay backs will reduce the availability of FQHC funds for near-term expansion.

At this stage, BHCDA has no explicit policy on the treatment of retroactive FQHC reconciliation payments. This could be a problem over the next few years, as cost settlements occur. We present related policy issues and implications in Chapter V.

Although the reconciliation process is structured to ensure reimbursement of full cost and to promote accountability, it has both positive and negative implications for centers. On the positive side. centers are less likely to over-commit dollars for projects that may not be sustainable or self-supporting over the longer term. On the negative side, over the near term, centers continue to operate in a "grant-like" environment (for example, fixed budgets and periodic lump-sum payments).

Early implementation centers are operating in a transition environment. Shifting from a predominately grant-budgeted environment, in which resources may be constrained but predictable. to FQHC presents fiscal uncertainties that translate into management challenges. However, as FQHC programs mature, it is anticipated that centers' reconciliation fears will diminish, and FQHC payments will flow more smoothly and predictably. This will allow centers to plan and finance incremental improvements in service delivery.

C. MANAGEMENT CONSIDERATIONS AND STRATEGIC PLANNING

At the outset of this study, we anticipated that the promise of substantially higher Medicaid revenues and opportunities for expanding capacity would result in FQHC-focused strategic planning. During the site visits, we sought to determine whether, and the extent to which, centers were making management changes to accommodate FQHC implementation requirements and the service expansion expectations.

Our case studies indicate that in addition to finding ways to adapt to the lags in payment discussed previously, management priorities focused on developing the data to support cost reports

and upgrading systems to facilitate tracking costs and improving billing systems. For most of the study sites, planning for allocation of FQHC revenues was evident but did not involve a formal FQHC-focused strategic planning process.

1. Management Information Systems

One of the consequences of shifting to cost-based Medicaid reimbursement is the centers' need for more detailed data on costs, services, encounters and patients. Several centers were able to adapt their systems to accommodate additional data (for example, Eagle Pass); other centers are up-grading their data collection and automated management information systems (for example, Providence).

Enhanced management information systems are clearly important for the FQHC program; these systems provide data that are essential for cost accounting, preparation of annual cost reports, and reconciliation audits. Although centers recognized that the potential value of improved data management and analysis capabilities extend beyond the FQHC reporting requirements, they most frequently commented on the costs of up-grading and maintenance. Centers' actual or planned investments in data improvements and reporting capacity were targeted primarily to meeting the data demands of cost accounting, billings, accounts receivable monitoring, and audits. Broader applications, such as profiling service use by patients, tracking appointments, or monitoring quality, did not appear to be a high priority, although some centers are moving in this direction. Centreville, for example, is purchasing a computer system that will improve patient tracking and clinical monitoring of care.

2. Setting Priorities for Future Expansion of Capacity

With the exception of a few centers that recently engaged in more formal strategic planning (Axton, Cairo, and Milwaukee), the centers appear to rely on long-standing familiarity with their strengths, resource weaknesses, and community needs in order to set priorities for expanding capacity. For the most part, centers are using their established planning and decision-making processes.

Generally, the center's executive staff are responsible for short-term operational planning. The board of directors, in turn, is involved in reviewing annual plans and budgets prepared by staff, as well as in setting priorities.

FQHC is one of several variables in a center's review of the staffing and resource requirements needed to meet current or projected demands for services. Other critical variables include assessments of community needs (for example, periodic surveys), the potential market for new or expanded services, grant funds to support additional services, Public Health Service/BHCDA mandates, and the center's mission. The annual assessment and review activities tend to be less structured than a formal strategic planning process that requires rigorous quantitative analyses of market opportunities and financial impacts.

Milwaukee is the only study site to use a consulting firm in order to develop its long-term strategic plan. However, it is important to note that Milwaukee's planning process began before FQHC implementation and focused primarily on assessing options for expanding service delivery capacity (for example, creating a satellite site versus current site expansion). The executive director is in the process of conducting a comprehensive needs assessment, including primary data collection on use patterns, competitors, and health care preferences among the target populations.

Axton is the only study site that participated in a statewide FQHC strategic planning process. The Virginia PCA felt that, given the potential of FQHC for its members, it was useful to assist centers in undertaking a multi-year strategic planning program. C/MHCs are accustomed to planning within the framework of annual grant submissions. In contrast, the PCA-sponsored strategic planning process featured technical training sessions, hands-on workshops, and a three-year time horizon.

Each center in Virginia developed a multi-year strategy for investing anticipated FQHC revenues. The resulting financial plans included proposed expansions and a preliminary assessment of their revenue effects. The centers will review and update these plans **annually_**

It important to note that Axton's three-year plan is based primarily on knowledge of its community and previously identified resource and service-enhancement needs. As such, Axton's plan did not involve sophisticated primary data collection or a rigorous bottom-up assessment of community needs.

Our original hypothesis, that the FQHC program would lead centers to engage in formal and rigorous strategic planning efforts, has not been confirmed by the site visits. Similarly, our assumptions that centers anticipating very large revenue increases might be hard-pressed to identify opportunities for expansion or that they would seek to examine the financial impact of alternative investments, are not valid. Our site visits clearly indicate that most centers are making FQHC allocation decisions on the basis of previously developed long-range plans or "off-the-shelf" plans that reflect long-standing center priorities for redressing service and capacity deficits. These centers felt that specific FQHC-related plans were not needed.

3. Prevailing Constraints on Centers' Planning Activities

Strategic planning requires a long-term time horizon. The absence of FQHC-focused planning activities may also reflect skepticism about the future of FQHC. Centers already face persistent payment lags and uncertainty about final cost settlements. A number of centers expressed concerns about the future scope, if not viability, of the FQHC program. HCFA's delay in issuing FQHC regulations further fueled concerns about possible revisions in state payment methodologies.

Even when dollars are available, some centers are planning for capacity expansions very cautiously. Some centers, in particular, were reluctant to commit reconciliation funds until the revenue effect of the FQHC stabilizes. There have been rumors that Medicaid programs may impose a cap on FQHC reimbursements, and respondents expressed continuing fears that the BHCDA will reduce its grants. Skepticism is understandable in light of the large deficits states are facing and the substantial initial increases in center Medicaid revenues discussed previously in this chapter. While FQHC represents a very small portion of a state's Medicaid budget, centers fear that states may

nonetheless elect to revise FQHC payment methodologies in ways that would restrict level of payments (for example, imposition of rate caps; redefine what constitutes reasonable costs; or apply screens that effectively reduce center payments).

Medicaid managed-care initiatives may further complicate centers' ability to project FQHC Medicaid revenues. For example, Maryland recently obtained a HCFA waiver requiring enrollment of Medicaid recipients by participating providers, including FQHCs. Since Maryland providers will only receive FQHC payments for enrolled Medicaid patients, a competitive environment exists. The Maryland center will be able to project FQHC revenues only after the completing the first cycle of Medicaid enrollments.

Centers under Medicaid managed-care programs such as Maryland's are also concerned that, during the initial phase-in, Medicaid recipients, who are enrolled with other providers, may also seek services from the center. For some Medicaid beneficiaries, it takes time and counseling to become accustomed to using only their designated provider. Medicaid will not pay a center for services to a patient enrolled with another provider (without authorization). In these circumstances. centers will be forced to refuse treatment or to accept these beneficiaries as sliding-fee patients.

In sum, what emerges from site visits with these early implementation centers is a predominant attitude of "cautious pragmatism" in response to a climate of substantial fiscal uncertainty. The uncertainty is due to the unpredictability of lags in payment, caution about and end-of-year reconciliation process, and fears that the program will not last. Moreover, as is evident in the next section on the allocation of revenue, centers have a substantial backlog of previously recognized, but unfunded, priority needs. Under such conditions there is a limited incentive to undertake long-term strategic planning related specifically to Medicaid revenues.

D. ALLOCATION OF FQHC REVENUES

1. Factors That Might Influence FQHC Revenue Allocation Decisions

As the preceding discussion indicates, centers are tending to operate as small and conservative businesses in response to cost-based reimbursement under the FQHC program. Interviews suggest that decisions about the use of FQHC revenues take into account the centers' missions, fiscal situations, and political environments. Key factors include:

- Anticipated level of FQHC revenues
- Actual or predictable flow of FQHC revenues
- Possible revenue impact of reconciliation
- Potential implications of state's fiscal and Medicaid budget situation for future level of FQHC payments, including changes in methodology for setting rates and reimbursement limits
- Pre-existing plans for capacity expansion

The relative importance of each of these factors on FQHC revenue allocation plans varies across our nine sites. For example:

- Predictable revenue flow is a prevailing concern for study sites in Illinois (Cairo and Centreville) and Rhode Island (Providence).
- Uncertainty about the reconciliations and future revenues are considerations for study sites in Wisconsin (Milwaukee and Minong), Texas (Eagle Pass and Dallas), and Maryland (Baltimore).

The anticipated level of FQHC payments might also influence both the scope and type of projects. Five of the study sites estimate first-year FQHC payments in excess of $500,000 (Cairo, Centreville, Providence, Eagle Pass, and Milwaukee). However, the extent to which the projected level of FQHC payments translates into ambitious capacity building plans is likely to be influenced by the predictability of the FQHC payment flow.

2. Uses of FQHC Revenues

Despite articulated concerns about payment flow and the future of the FQHC program. the individual center's actual and planned FQHC allocation decisions differ considerably according to the extent to which the centers are committing FQHC revenues to expand capacity. Among our study sites, three patterns are emerging:

1. ***Major Capacity Expansion.*** Commitment of resources for construction of new or expanded facility or satellite clinic (Cairo, Centreville, Eagle Pass, Milwaukee, and Minong)

2. ***Modest Capacity Expansion,*** Renovations for expanding services within current facility, related staffing, and equipment priorities (Baltimore, Dallas)

3. ***Critical Capacity Maintenance.*** Emphasis on improving access, current capacity, and existing scope of services (Axton, Providence)

Interestingly. there is little, if any, discernible match between the level of FQHC revenues and the level of commitment to major capacity expansion projects. For example, Minong with $152.007 in first-year FQHC revenues joins other sites with high projected FQHC revenue (for example, Cairo with $1.3 million in projected FQHC revenues). The pre- and post-FQHC percentage increase in Medicaid may be a partial explanatory factor (74% for Minong, compared with 48% for Cairo), but pre-post percentage increases in Medicaid revenues are substantial for all of the study sites.

Similarly, articulated concerns and evidence of payment flow problems do not appear to have had a consistent across-the-board impact on the capacity expansion plans of individual centers. 'The sites planning major capacity expansions appear to have a long-standing interest in expanding capacity in order to meet acknowledged access problems within their communities. FQHC revenues provided the necessary resources. At this stage, however, we have insufficient experience, data and sites for identifying the determinants of alternative FQHC supported expansion strategies.

Table IV.3 summarizes centers' plans for allocating FQHC revenues by study site. Appendix A provides more detailed profiles of each center's plans for allocating FQHC revenues. Summary information is provided in three categories:

1. Facilities, including renovation and more substantial construction or capacity-expansion projects (for example, establishment of a new satellite clinic)

2. Staff, including recruitment and compensation-related plans for increasing delivery-system capacity (recruitment) or promoting retention critical for maintaining capacity (enhanced compensation)

3. Equipment, including diagnostic (new services), additional treatment suites (expanded capacity), transportation vans and mobile unit (facilitate access), and computers and management information systems

With the exception of Axton and Providence, FQHC revenues are primarily supporting plans to expand physical capacity. Satellite clinics will be established by Cairo, Centreville, and Minong. Expanding current facility-capacity (size or treatment suites) is a priority for Baltimore, Dallas, Eagle Pass, and Milwaukee.

It is understandable that staffing is a high priority for all of the study centers, particularly in light of physical expansion plans. Demand for maternity and pediatric care has been increasing as a result of Medicaid's recent eligibility expansions for pregnant women and children. Centers are emphasizing the recruitment of obstetricians, pediatricians, and mid-level staff. Providence, more so than the other study sites, is emphasizing recruitment in critical areas--ten nurses/nurse practitioners, one obstetrician, and one pediatrician.

Similarly, equipment and furnishings for treatment suites are driven by expanded site and satellite capacity plans. Two study sites are investing in management information systems.

E. MAJOR FINDINGS AND CONCLUSIONS

With the inception of the FQHC program, there was some concern about the ability of the centers to adapt to the new financial environment. Payment reforms engender powerful incentives.

TABLE IV.3

FQHC REVENUE ALLOCATION PLANS--EXPANDING SERVICE DELIVERY CAPACITY

Center	Facilities	Staff	Equipment
Illinois			
Centreville	Establish satellite clinic (E. St. Louis).	Revise compensation - increase salaries and productivity bonus system.	Purchase computer system.
Cairo	Construct new "mega-clinic"; establish satellite clinic.	Two PT OB/GYNs & FT nurse practitioners.	Furnishings for new clinics.
Maryland			
Baltimore	Renovations, including new roof, practice suites and powerline.	Recruit an OB and support staff to achieve years' staffing level.	Upgrade equipment (screening and diagnostic) and office furnishings. Upgrade data management and billing systems, including both hardware and software.
Rhode Island			
Providence		Recruit additional staff at all levels; compensation related insurance expenses.	Vans for transportation services.
Texas			
Dallas	Establish satellite clinic and/or renovate space in main building.	Improve compensation for all staff.	Upgrade x-ray equipment; mobile unit.
Eagle Pass	Construction of replacement building for clinic services.	Improve compensation and recruit physicians and other health professionals.	
Virginia			
Axton		Add a second full-time physician.	QBC-II and cast saw.
Wisconsin			
Milwaukee	Expand existing building.	Recruit and improve staff compensation.	Add and equip new treatment rooms.
Minong	Establish satellite clinic.	Recruit physician & re-establish Tribal Services (at satellite).	X-ray equipment for satellite clinic.

At the outset, it was unclear whether centers would be able to respond in a timely and judicious manner to cost-accounting requirements. FQHC implementation placed considerable demands on the centers' financial, data, and management systems. In addition, there was some concern about the response of the centers to lump sum payments which would result in a sudden jump in revenue. For example, would centers take on ongoing financial commitments in advance of sufficient and stable revenue flow? Would precipitous decisions to provide new services be taken without assurance of anticipated patient demand and/or with an insufficient number of providers available to meet rising demand.

Importantly, we observed that these potential problems have not notably materialized. Among our study sites, we have found that centers have diligently prepared for FQHC implementation and have apparently been cautious in allocating FQHC revenues to the extent to which such dollars have been paid.

The case studies indicate that in the initial reaction to the FQHC program:

- ***Centers participated in a variety of pre-FQHC implementation training sessions on cost-accounting procedures and preparation of cost reports.*** Some technical issues have yet to be resolved. Few, if any, changes are likely to occur while states continue to await issuance of HCFA's FQHC regulations.

- ***Centers did not go on a spending spree.*** Although most centers did not engage in a formal strategic-planning process, FQHC investment decisions primarily reflected knowledge of the centers' most pressing needs that could now be addressed. Centers anticipating (or even experiencing) substantial first-year revenue increases have not made commitments that would outpace their cash flows. There appears to be a rather conservative fiscal attitude among centers which may reflect years of managing with limited resources. Where state Medicaid agencies have been rather slow in making payments (for example, Rhode Island), centers are not in a position to capitalize on the potential revenue of FQHC.

- ***The centers' FQHC revenue allocation patterns suggest that centers are proceeding cautiously and strategically in positioning themselves to better serve their target communities.*** Although study sites have not engaged in very formal strategic planning exercises specific to FQHC, strategic thinking is clearly evident. For several centers, the first FQHC dollars are being spent on priority projects that had been delayed during the lean years.

- ***Study sites are involved in different, albeit interrelated, phases of building the infrastructure for expanding service delivery capacity. The*** emerging hierarchy of FQHC revenue allocation decisions--or investments--is logical:

  - First, expand clinic space. or renovate space to accommodate more practice suites and related service and administrative areas.

  - Second, increase staff (physicians and mid-levels), particularly in areas of highest demand (for example, perinatal and pediatric care). Review and, if appropriate, improve staff compensation in order to compete for talent and skills, and equally important, to retain valuable staff.

  - Third, identify service area gaps and obtain necessary equipment and staff to provide additional services. Several study sites have identified medical equipment and transportation vans as important service expansion areas.

- ***Thus far, intensive recruitment of new users has not been an immediate priority among the study sites.*** In part, this may be due to the fact that several study centers are now at capacity or even exceeding acceptable limits (for example, long waiting lists or lengthy waits for appointments). In our study sites, the need for primary care tends to outstrip capacity. As a consequence, study sites have focused first on building delivery system to meet services demand within their communities. The next logical step is likely to be greater emphasis on outreach to both Medicaid and low-income uninsured families.

- ***Centers have not marketed aggressively to Medicaid patients in order to generate even higher annual revenues.*** Although the number of Medicaid patients has increased during the past several years, this trend appears to be primarily the result of Medicaid eligibility expansions, rather than of aggressive outreach and marketing campaigns. Several study centers (for example, Axton and Baltimore) expressed concerns that the rising number of Medicaid users might affect their primary mission of serving uninsured, low-income families. That is, if the center is at capacity, aggressive marketing to Medicaid patients could crowd out the uninsured. In at least one instance, the rising number of Medicaid users was viewed as a potential threat to the center's ability to serve its target population--low-income families--on a sliding-fee basis.

V. METHODS FOR DOCUMENTING THE REVENUE EFFECTS OF THE FQHC PROGRAM

Accurately determining the effect of the Federally Qualified Health Center (FQHC) legislation requires accounting for the impact of numerous changes in Medicaid and separating these factors from the rate changes due to the new cost-based reimbursement system. This chapter discusses (1) recent Medicaid amendments that affect revenues to health centers, (2) the purposes of estimating the effect of the FQHC, (3) the data that might be used for such analyses, based on review of the nine centers, (4) implications of retroactive cost settlements, and (5) alternative approaches that might be considered by the Bureau of Health Care Delivery and Assistance (BHCDA).

A. MEDICAID EXPANSIONS DURING THE 1980s

The FQHC is only one of a number of recent changes in federal requirements affecting state Medicaid programs. During the late 1980s, the Congress enacted substantial expansions of Medicaid eligibility for pregnant women and children and increased the scope of services available to Medicaid-eligible children. At the same time, states took advantage of new service options and began to cover expanded perinatal services, such as case management, risk assessments, and home visits.

To understand fully the effect of the FQHC, its provisions need to be viewed within the context of overall trends in Medicaid. Major changes since the mid-1980s include:

- ***Eligibility Enhancements.*** Each year since 1986, Congress has expanded optional and mandatory coverage of pregnant women and children. The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) mandated coverage of pregnant women and children to age five years with incomes below 133 percent of the poverty level. OBRA-90 phased in mandatory coverage of children with incomes below the federal poverty level who were born after September 30, 1983. Since 1987, states have had the option of increasing Medicaid eligibility levels for pregnant women and infants to 185 percent of the federal poverty level. In 1992, 23 states had increased eligibility for pregnant women and infants to this level. Effective September, 1992, all states cover children to age 5 with incomes below 133 percent of the poverty-level and cover children up to age 9 years with incomes below the federal poverty level (National Governors' Association, 1992).

- ***Enrollment Simplification.*** OBRA-90 required that states locate Medicaid eligibility workers at disproportionate share hospitals and FQHCs, in order to expedite the eligibility process for pregnant women and children. The statute also required simplification of the application forms.

- ***Enhanced Perinatal Services.*** Throughout the late 1980s, states expanded the scope of services available to pregnant women. By January of 1992, 38 states were covering case management and risk assessments; 30 covered nutritional counseling and health education; 31 paid for home visits and 8 paid for transportation (National Governors' Association, 1992). All but one state (Oklahoma) adopted these expansions prior to July, 1991.

- ***Expanded Children's Services.*** OBRA-89 also amended Medicaid's Early Periodic Diagnostic, Screening and Treatment (EPSDT) program for children. Under these amendments, states were required to cover any medically necessary treatment for a condition diagnosed through EPSDT, as long as the items or services are reimbursable under federal Medicaid law. The statute required that the state pay for these services, even if they were not otherwise included in the state's Medicaid plan. Thus, normally optional services (for example, preventive services, rehabilitation, transportation, physical therapy, and speech or hearing therapy) were now mandated for children under age 21 requiring this care.

Even in the absence of the FQHC, one would expect these changes to generate rising levels of Medicaid reimbursement to health centers. Increasing Medicaid eligibility levels mean that uninsured women and children who use health centers become eligible for, and enroll in, the program. As the scope of Medicaid-covered services expands, health centers can claim reimbursement for services that were previously not paid for by Medicaid. In addition, the current recession can have two contradictory effects. On the one hand, increases in unemployment generally lead to higher Medicaid enrollment and would be expected to generate increased Medicaid utilization at the centers. On the other hand, state fiscal problems may result in payment delays or the imposition of limits on reimbursements.

Nationwide trends show that Medicaid revenues to community and migrant health centers (C/MHCs) were increasing before passage of FQHC. In 1988, C/MHCs received approximately $170 million from Medicaid, about 18% of total revenues. Medicaid revenues rose to $217 million in 1989,

and to $259 million in 1990 (20% of the total).[1] **Given the slow pace** of implementation, the 1990 **revenue increase cannot be primarily attributed to the FQHC program.**

B. PURPOSES OF DOCUMENTING THE REVENUE EFFECTS OF FQHC REIMBURSEMENT

There are two primary reasons for determining the revenue effects of the new program:

1. ***To monitor implement&ion of the legislation*** by tracking changes in FQHC-Medicaid revenues over time
2. ***To evaluate the effect of reimbursement rate increases as*** distinct from eligibility and service expansions

Both of these objectives are important. Monitoring changes in reimbursement permits examination of the extent to which the legislation is being implemented. Over time, one would expect the proportion of total center revenues derived from Medicaid to rise--approaching the same level as the proportion of total services (or encounters) that centers provide to the Medicaid population. Such a trend would indicate that the Public Health Services (PHS) grant subsidy of costs of serving Medicaid patients had been substantially reduced or eliminated.

Evaluating the revenue effect of rate increases under the FQHC seeks to determine the unique impact of cost-reimbursement on the Medicaid revenues of eligible clinics, as distinct from the many recently adopted eligibility and service changes.

Results of the site visits indicate that a number of factors are contributing to Medicaid revenue increases. For most of the centers, the numbers of Medicaid users and encounters have risen, attributed principally to (1) increases in enrollment by children, (2) outstationing of eligibility workers, and (3) general economic trends. Although there has been little aggressive outreach to the general Medicaid population to date, three centers have eligibility workers located on their premises and are

[1] These data were provided by BHCDA from the BCRR/BHCDANET system. Data include the 50 states and the District of Columbia; the territories are not included. **The data were edited by** MDS Associates to adjust for several cases in which Medicaid-HMO revenues were reported as "other third party."

actively enrolling current users who are eligible in Medicaid. At the same time, state fiscal problems have led to significant payment delays in some states.

As revenue continues to rise, disaggregating the effect of rate increases may become important, particularly in light of the issues that state agencies raised about cost-based reimbursement and FQHC expenditures.

Monitoring and evaluation address different issues and call for different methodologic approaches. However, both rely primarily on data maintained by, and available from, the centers. We discuss these data in the following section.

C. DATA AVAILABLE AT THE CENTERS

In the past, information on Medicaid utilization of community health centers has been limited. Indeed, the comparison of changes in Medicaid revenue before and after the implementation of the FQHC program presented in the previous chapter illustrates the difficulties of developing consistent, comparable estimates from available data. BHCDA's standard reporting form (the BCRR) does not identify users or encounters by insurance status. User data are reported by age and sex for medical and dental services. Encounters are reported separately for medical and dental services. Encounters are also broken down by type of provider within the two categories (for example, physician, mid-level medical, dental hygienist). Although most centers provide information on users by insurance status in their grant applications, they do not report the numbers of encounters by this variable.

Availability of data that are not required for standard reporting by individual centers has also varied greatly. Before the FQHC program, some grantees had highly sophisticated billing systems with detailed service-specific records and regular report generation. Others used paper billing systems and card files and had little ability to aggregate data routinely.

The FQHC appears to have be improved data on Medicaid utilization of the C/MHCs. As one center commented, "We didn't keep detailed data before because we didn't have an immediate use for it." The need for better information in order to prepare FQHC cost reports, coupled with a

center's interest in maximizing levels of potential revenues, almost guarantees improved data systems for Medicaid. On the other hand, these systems do not produce uniformly-defined information for all centers. The centers maintain data in a manner appropriate to documenting costs under their states' particular reimbursement systems. The available information varies in part because the state payment methodologies and rules vary.

To illustrate the problem, Table V.l summarizes the types of data that are potentially available at the nine study centers. These data fall into two principal categories:

1. ***Medicaid users,*** including users by Medicaid eligibility status (for example, recipients or AFDC pregnant women). This is the basic information needed to examine the effects of changes in Medicaid eligibility provisions on reimbursement.

2. ***Medicaid encounters,*** including encounters by type of service. This is the information needed to examine the effects of changes in Medicaid service coverage on reimbursement.

1. User Data

Information on Medicaid users is required in BHCDA grant applications. These were the data provided to the site teams. The table in the grant application requests information on the number (or proportion) of users by insurance status; instructions request data for the last full 12-month period for which the center has information.

Data in the grant application are intended to provide an overview of the health center's population. They have not been previously used by BHCDA for rigorous analyses. As such, Medicaid user data differ among centers, and analyses of these data have raised some questions about their usefulness for cross-center analyses (MDS Associates, 1991). If centers were reporting users by insurance status for the current year, one would expect the total number of users reported by insurance status to approximate, if not be identical to, the number of C/MHC users reported on the BCRR. Examination of reported information from 445 centers shows that:

TABLE V.l

SUMMARY OF CURRENT DATA AVAILABLE AT THE CENTERS AS OF EARLY 1992

Center	Medicaid Encounters	Medicaid Users	Medicaid Eligibility Status	Encounters by Type of Service
Illinois				
Cairo	**Yes**	**Yes**	No	Yes; CPT4 codes on the billing form. Prenatal and inpatient OB separate; paid FFS.
Centreville	**Yes**	**Yes**	No	Yes; CPT-4 codes on the billing form. Prenatal and inpatient OB separate; paid FFS.
Maryland				
Baltimore	**Yes**	**Yes**	No; can separate HMO members.	By departments: OB-GYN; FP; Peds and EPSDT; Adult; Dentistry; Targeted Case Management
Rhode Island				
Providence	**Yes**	**Yes**	No; can separate state-only (GPA) because paid at lower rate	Medical; dental; prenatal
Texas				
Eagle Pass	**Yes**	**Yes**	No	EPSDT,FP,Pharmacy separately identified; bills include procedure codes and provider type (e.g. psychologist; social worker)
Dallas	**Yes**	**Yes**	No	EPSDT,FP,Pharmacy separately identified; bills include procedure codes and provider type (e.g. psychologist; social worker)
Virginia				
Axton	**Yes**	**Yes**	No	Available for initial start-up period only;
Wisconsin				
Minong	**Yes**	**Yes**	No	No
Milwaukee	**Yes**	**Yes**	**Yes**	Available for HMO patients

- 154 centers (35 percent) reported more users by insurance status than reported total users. For the average center, the difference was more than 6,000 patients.
- 181 centers (41 percent) reported fewer users by insurance status than reported total users, with an average difference of more than 2,300.

Review of the reported information, in hard-copy, suggests two distinctly different explanations for this phenomenon. First, centers use sample data covering less than one year to prepare information for the grant application. Unless the data are inflated, reported Medicaid users are understated. Second, some centers appear to report encounters by insurance status, rather than by users. This yields an overstatement of the proportion of Medicaid users.

Data on Medicaid users, by Medicaid eligibility category, do not appear to be readily accessible at present. Only one of the visited centers seems to have such information. Most of the centers could report only anecdotally on changes in their caseloads and particularly noted that, increasingly, children using the center were eligible for and enrolled in Medicaid.

It is important to recognize that Medicaid user data, although of great interest for analytic purposes, has limited utility for a center's on-going operations. Most centers bill Medicaid on the basis of encounters. Because most Medicaid services are available to all Medicaid recipients, centers have little need to know the manner in which a recipient qualified for Medicaid. There are two major departures to this rule:

- ***State-Funded Recipients.*** In addition to recipients for whom federal matching funds are available, some states cover additional groups with state-only dollars. The FQHC requirements apply only to federally reimbursed eligibles. In Wisconsin and Rhode Island, services to these "state-only" recipients are paid for at another rate.

- ***Managed Care Systems.*** State managed care systems do not always include all categories of eligibles. The only center having some information on users by eligibility category currently participates in a Medicaid HMO. Maryland's new program (Maryland Access to Care, or MAC) does not require enrollment in managed care of women who are eligible because of their pregnancy. As the MAC program is implemented, for billing purposes, centers may need to separately identify pregnant women who are eligible under the Medicaid expansions.

2. Encounter Data

All nine centers maintain data on Medicaid encounters, both for billing purposes and for preparation of their cost reports. These data appear to constitute a more reliable source. of information on Medicaid utilization than the user-based data in the grant application for Section 329/330 funding. The centers all bill on an encounter basis and use these data for cost reports and establishing audited Medicaid rates by the state. In at least one state (Virginia), the Medicaid agency itself provided data from administrative files on billed encounters for the centers' use in compiling cost reports.

The level of detail on the type of encounters, however, varies greatly among the states. Payment methodologies also vary among the states, although all now use inclusive rates for basic medical services.[2] Because these rates do not differentiate among discrete services, changes in the service package for Medicaid recipients cannot be identified from encounter data alone.

- Two states (Illinois and Texas) include procedure codes on the billing forms, but these encounters can include more than one procedure.
- In Texas, family planning, EPSDT, and pharmacy services are not in the inclusive rate and continue to be billed on a fee-for-service basis.
- In Maryland, Rhode Island, and Wisconsin, encounters could be disaggregated to some extent, but not at the level of specific procedures or covered services. For example, Rhode Island established separate rates for medical and dental encounters, and obstetric services are being billed under a separate method.

The definition of an encounter poses another constraint on use of the data. None of these states used the BCRR definition, which permits recording one medical encounter, one dental encounter, and one other health encounter for each type of other health provider (for example, psychologist, family planning counselor) per day (emphasis added) (BHCDA, 1991, page 111-6). All of the visited

[2]During the first phase of implementation, centers in Virginia and Texas billed on a procedure-by-procedure basis. With establishment of cost-based rates, this interim billing method has been discontinued.

states based their definitions of an encounter on the concept used by the Health Care Financing Administration in the Federally Funded Heaith Center (FFHC) and Rural Health Clinic (RHC) programs. Under these reimbursement programs, which predate the FQHC legislation, all contacts occurring between a patient and providers on a single day constitute a single encounter. The BCRR definition yields a higher number of encounters than that used for Medicaid purposes. Thus, comparing the two data sets would tend to understate the proportion of CHC services received by Medicaid recipients.

Although the states use a common approach to defining a Medicaid encounter, there is little consistency in the specific definition. The key difference lies in the definition of who provides a "billable encounter."

- Maryland defines an encounter as "a face-to-face contact between a clinic patient and a physician or other provider."
- Rhode Island is using the FFHC cost report, with minor modifications to the definition of non-allowable costs. Only contacts with physicians are treated as billable encounters.
- Texas lies at the other extreme, including face-to-face contacts'with a "physician, physician assistant, nurse practitioner, nurse-midwife, psychologist, social workers, or a visiting nurse" as billable encounters.[3]

Differences in the definition do not necessarily affect total Medicaid revenues received by centers, because cost reports include the allowable costs of all services, including those not counted as a billable encounter. However, these differences do have important implications for analysis of the FQHC experience. A good example is the treatment of services provided by clinical social workers, one of the newest expanded services for FQHCs. Wisconsin does not count these services as a billable encounter, although the costs are included in the allowable cost base. Texas, on the other hand, permits billing a social work encounter as a separate service. Comparing similar centers in these two states might show the Wisconsin center to have fewer encounters and a higher cost-

[3]National Heritage Insurance Company, Instruction letter to FQHCs, September 30, 1991.

based payment rate than the Texas center. In reality, the two might have the same total cost of serving the same number of Medicaid patients, with the apparent rate differential being an artifact of payment methodologies and definitions.

3. Implications

It is often said that the nature and quality of data are directly related to their utility. Early experience with the FQHC program confirms this view. When adapting to the new payment system, the centers have established systems and reporting methods that provide heretofore unavailable data on Medicaid utilization.

Our review of the data at these centers leads to four conclusions:

1. The quality of Medicaid encounter data is improving and is likely to become more reliable over time. At the moment, there does not seem to be a similar impetus to generate comparable improvements in the quality of Medicaid user data. The primary qualification to this conclusion is the growing interest among states in Medicaid managed-care programs. *If* these programs base reimbursement on services to individuals (for example, capitation) rather than on numbers of encounters, one could anticipate similar improvements in the quality of user data.

2. Data maintained by the centers do not appear to provide the level of disaggregation on Medicaid eligibility or changes in discrete services needed to evaluate the effect of FQHC rate changes. Procedure codes seem to have been included by some states in order to facilitate utilization analyses. For individual centers' daily operations, these data may have minimal utility, as centers bill Medicaid on an inclusive rate basis, and cost reports allocate costs by department, not by service.

3. Differences in state detinitions of a billable encounter impose major constraints on using these data for comparative purposes across states, although they are less likely to affect intra-state analyses. These differences are likely to persist, HCFA promulgates rules that establish uniform definitions. The eventual issuance of regulations for Medicare-FQHC might lead to some uniformity across the states. However, differences in the treatment of Medicaid-covered services appear likely to persist.

4. Differences between the BCRR definition of an encounter and the definition of a Medicaid billable encounter are likely to complicate future analyses. There are no easy solutions to this problem. Clearly, changing the BCRR definition affects the utility of the BHCDANET data system, which has been used to monitor changes in utilization for years. Alternatively, converting Medicaid billable encounters to fit the BCRR definition may be difficult, if not impossible. With the

increasing importance of Medicaid as a revenue source for centers, options for resolving these definitional problems should be explored.

D. IMPLICATIONS OF RETROACTIVE COST SETTLEMENTS

Retroactive cost settlements pose reporting issues with major implications for analyses of revenues to C/MHCs over time. Four of the visited states (Maryland, Texas, Virginia, and Wisconsin), have adopted payment methodologies providing for retroactive settlements to ensure that Medicaid payments cover reasonable costs. As noted throughout this report, the transition process has produced delays that virtually guarantee sizable lump-sum cost settlements for the centers. As shown in Table V.2, lump-sum cost settlements amounted to an estimated 16 to 70 percent of 1991 Medicaid revenues for the nine study centers. As FQHC implementation proceeds, and cost-based rates are established, one would expect the size of these settlements to diminish. However, many states have not yet conducted reconciliations and retroactive lump-sum payments are likely to occur for some time.

Data problems arise because revenues received in a retroactive settlement are actually attributable to services rendered in a prior year. In the six states that we visited, for instance, the 1991 Medicaid payments were for costs of services provided during 1990. This poses two analytic problems:

1. Analyzing changes in Medicaid cash revenues will yield unusual trends, with peaks and valleys in particular years. It would be faulty to conclude from the analyses in this report that the level of revenues received by some centers in 1991 would continue.

2. Comparing revenues in a given year with encounters for that year is faulty, since revenues would include some payments for services in a previous year.

Under accrual accounting principles, the retroactive settlements should be credited to the year for which they are applicable, rather than to the year in which they are received. However, the BHCDA reporting system focuses on cash receipts, not accruals. Instructions for the new BCRR

TABLE V.2

EFFECT OF RETROACTIVE COST SETTLEMENTS ON 1991 MEDICAID REVENUES

Center	Total	Revenues for Services rendered in 1991	Revenues from Cost Settlements Attributable to 1990 Services	
			Dollars	Percent
Illinois				
Cairo	$800,000	$710,000	$90,000	12.7
Centreville	$646,348	$556,348	$90,000	13.9
Maryland				
Baltimore	$125,315	$125,315	0	0.0
Rhode Island				
Providence	$1,321,385	$1,321,385	0	0.0
Texas				
Dallas	$373,428	$189,428	$184,000	49.3
Eagle Pass	$307,517	$173,517	$134,000	43.6
Virginia				
Axton*	$98,233	$50,181	$48,052	48.9
Wisconsin				
Minong	$90,303	$27,035	$63,268	70.1
Milwaukee	$352,400	$295,400	$57,000	16.2

*For 1991, 11 month data have been annualized

define the amount collected as "actual receipts during the period, as classified by source, for services rendered regardless of the period in which those services were provided" (BHCDA, 1991, page III-87). The description of "adjustments" implicitly assumes that these are reductions, not increases, in payments.

The current reporting tables were designed around a fee-for-setvice reimbursement system, rather than a cost-based system with retroactive payments. A variety of approaches might be used

to adjust reporting in order to account for retroactive settlements. Grantees might revise their BCRR data for prior years, as retroactive reconciliations are received, Alternatively BHCDA could clarify current reporting forms and instructions to fit new needs. Regardless of the approach selected, BHCDA must ensure that reconciliation payments are reported by grantees according to a uniform set of rules.

Lump-sum retroactive cost settlements also raise policy issues, with implications for the use of FQHC-generated revenues. Because retroactive settlements are received *after* services are rendered, they can be used to expand and enhance the capacity of a center to provide care for underserved populations. Moreover, BHCDA's Excess Program Income policy and the PHS statute permit these unanticipated revenues to he retained by the center. BHCDA has two policies regarding use of third-party revenues. The Excess Program Income policy addresses the situation when a center collects more third party revenue than originally projected in its budget for a particular year. As provided for in the Public Health Service Act, the policy seeks to encourage maximization of third party revenue by allowing such unanticipated revenue increases not to be offset against the BHCDA grant. However, if more than 50 percent of such revenues are spent on capital improvements, prior approval from the BHCDA regional office is required.

A second policy regarding use of on-going third party revenues is different. The total budget approach used to prepare grant applications requires centers to report total costs and anticipated revenues; the grant request represents the difference. Under FQHC, revenues will rise as Medicaid rates increase. Centers proposing to use FQHC revenues to expand services include the costs of those services in their applications and show the applicable FQHC revenues as non-Federal revenues. BHCDA has stated that projected FQHC revenue increases which are directed into recurring costs that expand services or patient caseloads (e.g. increased wage and salary expenditures for new personnel) will not result in reduced grants, provided that BHCDA gives prior approval for the proposed expenditures.

Recently, the General Accounting Office (1992, pp. 16-17) raised questions about these policies, noting that the PHS act "requires that health center grants not be more than the amount by which a grantee's operating costs exceed its revenues.... BHCDA's funding policy states that grants for centers will not be reduced as a result of additional revenues obtained through increases in Medicaid reimbursements.... this policy is inconsistent with the requirements of the PHS act."

E. APPROACHES TO DETERMINING THE EFFECT OF THE FQHC PROGRAM

In this section, we discuss the two approaches to determining the effect of FQHC reimbursement: (1) monitoring implementation and (2) evaluating the effect of rate increases separately from the impact of the Medicaid expansions and utilization. Each calls for a different methodologic approach. The former requires a consistent, on-going set of data, whereas the latter requires detailed data and complicated analyses that are conducted on a one-time basis. As costs rise, the need to distinguish the effects of rate increases from the expansions may increase, yet doing so will be more difficult to accomplish as the expanded Medicaid-eligible population and services become more difficult to separately identify.

1. Approaches to Monitoring Implementation

Monitoring changes in reimbursement permits the examination of the extent to which the goals of the FQHC legislation are being achieved. These goals are likely to evolve. For example, during the early period of implementation, BHCDA has been interested in projecting Medicaid revenues under FQHC by state. As the program is fully implemented and stabilized, revenue projections may become less critical, particularly, after all of the states have completed the transition to cost-based reimbursement.

For the long term, there are three monitoring questions of potential interest to BHCDA:

1. Have Medicaid revenues to participating clinics changed since implementation of FQHC?

2. Has the resulting subsidy of Medicaid services by BHCDA grant funds been substantially reduced or eliminated?

3. Has the level of Medicaid revenues per encounter changed since implementation of FQHC?

Table V.3 shows the formulas and data sources that can be used to answer these questions. **The** four data elements that are required are (1) total clinic revenues, (2) total clinic encounters, (3) total Medicaid revenues, and (4) total Medicaid encounters. The first three elements are reported to BHCDA on the BCRR; Medicaid encounter information is maintained by the centers and is included on their cost reports. The approach illustrated in Table V.3 assumes that the intensity of services (or encounters) to Medicaid recipients is the same as that for all C/MHC users.

TABLE V.3

MONITORING IMPLEMENTATION OF FQHC

Question to be Answered	Measure	Data Source
How have Medicaid revenues to CHCs changed since FQHC?	Current - 1989 Funds = Change	BCRR (or) other grantee annual reports
To what extent is Medicaid paying its fair share of costs for its patients? Is the proportion of revenues from Medicaid close to the proportion of encounters made by Medicaid patients?	Total Medicaid / Total Revenues = % from Medicaid Total Medicaid Encounters / Total CHC Encounters = % from Medicaid	BCRR (or) Medicaid cost reports
Have Medicaid revenues per encounter changed since implementation of FQHC?	Medicaid Revenues 1st year less Medicaid Encounters 1st year Medicaid Revenues current year / Medicaid Encounters	1st Medicaid cost report; current year cost report

Two previously discussed data limitations must be addressed before this approach can be implemented. First, revenues from retroactive reconciliations must be separately identified, so that

they can be attributed to the year in which services were rendered. Second, the problems arising from the use of different definitions of encounters must be resolved. The difference between the BCRR and Medicaid definitions need to be addressed in order to compare proportions of revenues and encounters from Medicaid accurately. Differences in state definitions of a Medicaid encounter may be less important if BHCDA wishes to track only the experience of individual centers. However, interstate comparisons require the use of a consistent definition of an encounter.

2. Approaches to Evaluating the Effect of Rate Increases

To evaluate the revenue effect of the FQHC program, one must distinguish the effect of cost-reimbursement from changes in the volume of services due to shifts in Medicaid eligibility or the breadth of covered services. The data should be detailed enough to track the number of Medicaid enrollees at C/MHCs by basis of enrollment (for example, pregnant women), the numbers and types of services used by each enrollment group, and the Medicaid revenues received. Similar data would be required for both the pre-FQHC and post-FQHC periods. A model based on these data would permit one to examine (1) enrollment effects (more Medicaid patients), (2) intensity effects (more visits per patient), (3) case-mix effects (different services received by patients), and (4) revenue effects (higher rates per visit).

The critical question is whether data are available that permit such disaggregated analyses. Our review of the data currently available at the nine centers suggests that:

- Detailed data for the pre-FQHC period are extremely limited. Many of the centers began to track Medicaid encounters only after FQHC was implemented.
- Data for the post-FQHC period are much improved, but do not provide the level of detail required. Information on Medicaid users, by basis of Medicaid enrollment, is not readily available; data on discrete services are not available in all situations.

Given these limitations, we considered three alternative approaches, each of which can provide at least partial answers to the evaluation questions.

a. Estimating Changes in Revenues, Assuming No Change in Medicaid Encounters

This approach uses a constant number of encounters and estimates revenues under two scenarios with and without the FQHC program. Three data elements are required:

1. Medicaid encounters in a particular year
2. Estimated revenue per encounter without **FQHC**
3. Prevailing FQHC payment rates

These data elements yield revenue estimates according to the following formulae:

(1) Total revenue without FQHC = [Medicaid encounters (1991)] x estimated revenue per encounter without FQHC

and

(2) Total revenue with FQHC = [Medicaid encounters (1991)] x [FQHC payment rate]

This option offers the simplest method for examining the revenue effects of FQHC. A clear advantage is that it relies on data that most centers are likely to have. Center-level data could be aggregated in order to arrive at statewide estimates. Because the method relies on available data, it could be implemented on an on-going basis, if desired. Although we used 1991 as the estimating year in this report, in applying the method to all centers one should use encounters from the first year of FQHC implementation.

This method does not account for changes in the number of Medicaid enrollees. Because it is based on encounters during a single year, it cannot adjust for dynamic trends affecting revenues (such as changes in the mix of services received by patients). It also ignores the impact of external forces on the Medicaid program. For instance, if a state increased physician payment rates during the time period in question, the revenues of centers are likely to have risen, even in the absence of FQHC.

Finally, the method assumes that centers can provide an estimate of revenue per encounter without FQHC cost-based reimbursement.

b. Detailed Review of a Sample of FQHC Cost Reports

This option attempts to sort out the effect of changes in the service package from changes in FQHC rates. Baseline data would be drawn from a center's first FQHC cost report, and compared with a subsequent year's report. The cost reports that we reviewed during this study include detailed information by major department (such as medical, dental, pharmacy, ancillary, and overhead). Some reports from Texas include disaggregated information on specific services, such as family planning, EPSDT, and pharmacy. The data would support two comparisons:

1. Estimates of Medicaid-covered costs and revenues in the first year of implementation, disaggregating costs associated with new or higher volumes of services
2. Comparison of Medicaid covered costs over time, with the same adjustments for services

This approach would be quite complex to implement. It requires a detailed understanding of each state's payment methodology and rules, as well the cost-allocation methods used by each center. It also requires documentation of changes in the cost-allocation methods. For example, for its first cost report, one center in Texas used the distribution of encounters to allocate costs of family planning. For its second report, it used the percentage of staff time as the allocation basis. Both methods were **equally** acceptable to the state.

Criteria for sample selection pose another set of considerations. On the one hand, one would want a group of centers that are representative of the variety of services provided and of the environments in which **C/MHCs** operate. On the other hand, one would want centers having somewhat comparable data sets, in order to draw reasonable conclusions about the universe of centers.

c. Using Multivariate Techniques to Analyze Medicaid Data

This approach uses state Medicaid data in order to develop the model that permits examination of enrollment intensity, case-mix, and revenue effects. Although this method may be relatively simple to describe, implementation would be complicated. Problems in addition to those associated with use of Medicaid data include:

- ***Identification of C/MHC Medicaid Claims from the Pre- and Post-FQHC Periods.*** Prior to FQHC, C/MHCs billed Medicaid under a number of different systems. In Maryland, Rhode Island, Virginia, and Wisconsin, centers had unique Medicaid billing number; those centers in Texas and some in Illinois billed under a physician's identifier. In the latter circumstance, methods would be needed to ensure that bills for center patients were separated from those of the provider's other patients.

- ***Linking Claims to Enrollees by Basis of Medicaid Eligibility.*** Although states maintain information on the basis of Medicaid eligibility, the categories can differ. In cases in which states use unique state codes to identify different groups of enrollees, detailed information on the state system is required.

- ***Identifying Discrete Services.*** For each billable encounter, two of the six visited states, (Texas and Illinois) include procedure codes, which can provide the basis for identifying changes in the service mix. Separate analyses to examine these changes would be difficult to perform if an encounter involves multiple procedure.

This approach may offer the only reasonable way of assessing the simultaneous effect of the wide variety of Medicaid policy changes, and of thereby identifying the effect of FQHC rates alone. State Medicaid data appear to be one of the few accessible sources of information on the basis of eligibility for Medicaid patients of C/MHCs. On the other hand, analyzing Medicaid data is extremely complex and costly. Whether such an analysis would be useful ultimately depends on BHCDA's assessment of the importance of documenting the extent to which different Medicaid policy changes have affected levels of C/MHC Medicaid revenues.

VI. CONCLUSIONS

The Federally Qualified Health Center (FQHC) program is still in its initial stages of implementation. The assessment in this report provides early information on the ways in which some states and centers are adapting to the new reimbursement system and enhanced Medicaid revenues. Although the findings of the case studies do not necessarily reflect the experience of all centers, they suggest important trends and issues for the future.

A. IS THE FQHC PROGRAM ACHIEVING ITS OBJECTIVES?

A primary objective of the FQHC legislation was to reduce the shift in costs from Medicaid to Public Health Service (PHS) grant funds. Ensuring reimbursement of the reasonable cost of services to Medicaid recipients would eliminate the need to use grant funds to pay for services to these patients. PHS grant funds could then be directed toward providing care for the uninsured, supporting needed services that are not Medicaid reimbursable, and generally expanding capacity to care for the medically underserved.

The experiences of the centers and states in this study suggests that, even at this early stage of implementation, the program is achieving its objectives. State payment methodologies are largely based on previously developed cost-based systems, such as the Rural Health Center (RHC) and the Federally Funded Health Center (FFHC) Programs, methods that result in payment rates per encounter that more nearly reflect costs. Although problems achieving comparable definitions make calculation of changes in payment rates difficult, available data indicate substantial, but variable, increases. In the Virginia center, reimbursement per encounter doubled while in the two Texas centers the rate more than tripled. In a rural Illinois center that was already on cost-based reimbursements as a Rural Health Clinic, the rate jumped by slightly less than 50 percent.

Ultimately, how effectively FQHC reduces the PHS grant subsidy of Medicaid services depends on the extent to which centers actually receive revenue at the FQHC rates. Although higher rates

are being translated into increased reimbursements, the extent to which revenues are approximating costs varies. In the visited states, payment delays result from three factors:

1. ***Transition Effects. The*** process of phasing in a new payment system is inevitably slow. Some states established interim payment methods below cost, until cost-based rates could be established. This transitional methodology inevitably results in substantial retroactive payments. The transition has also called for establishing new cost-reporting methods that require some states to devote considerable resources to conducting reconciliations and that have delayed the reconciliation process. As a result, virtually none of the visited centers had yet experienced a "full" effect of FQHC.

2. ***Payment Methodologies That Build in. Sizable Reconciliations.*** Some states have adopted a methodology that, when fully implemented, should yield revenues that are close to the costs of service in that year. Virginia, Texas, and Maryland are using cost-based rates, with retroactive reconciliations; Illinois and Rhode Island established prospective cost-based rates. However, in Wisconsin, the methodology provides for interim rates during the year and "wrap-around payments" in an end-of-year reconciliation. For the Milwaukee center that participates in a prepaid health maintenance organization this methodology is likely to yield revenues during the year that are lower than its costs.

3. State Payment Delays. In some states, particularly Rhode Island and Illinois, payment delays result from state fiscal difficulties, and not from the FQHC payment methods themselves. Centers in both of these states reported substantial amounts owed to them by the Medicaid agency.

A secondary effect of the FQHC program might be an increase in services to Medicaid patients. In particular, improved payment rates might be expected to provide incentives for centers to enroll more Medicaid recipients. Although virtually all of the centers reported that their Medicaid caseloads were increasing, this increase was not due to deliberate outreach efforts. Only three of the nine centers have responded to the FQHC program by attempting to market their services to Medicaid recipients who had not previously used the centers. Because most of the centers had reached their current physical and staff capacity, limited outreach efforts, whether to Medicaid or other potential users, is not surprising.

Medicaid enrollments at the centers are increasing, largely because of general economic conditions, higher unemployment, and expanded Medicaid eligibility, particularly coverage of children

at higher income levels. Implementation of the Omnibus Budget Reconciliation Act of 1989 (OBRA-89) requirements for outstationing of Medicaid eligibility workers is also a key factor. Centers that had outstationed workers were actively engaged in identifying potentially eligible patients and in assisting them to enroll in the program. For these centers, rising Medicaid caseloads represent a conversion of existing patients from "uninsured" to "Medicaid" status.

Targeting efforts toward Medicaid patients may raise implicit conflicts for some centers. On the one hand, provision of care to the ***underserved,*** which clearly includes the Medicaid population, is a primary mission of the centers. On the other hand, some centers articulate their mission as providing for the ***uninsured. The*** FQHC provides the opportunity for those centers to redirect grant dollars into their primary mission and enrollment of new Medicaid patients is not necessarily a high priority. For example, one rural center, which sees its role as provider of primary care for the ***entire community*** (including private-pay patients) expressed concern that significant increases in Medicaid caseloads might weaken its image.

The centers and states view the FQHC program from different perspectives. For the centers, FQHC ensures full payment from Medicaid and permits the use of grant funds to build capacity for the uninsured and underserved. In contrast, some state Medicaid agencies interpret the FQHC program as an opportunity to improve access to cost-effective care for Medicaid recipients and, ultimately, to provide program savings. For instance, one state official expressed the hope that FQHC would encourage Medicaid recipients to enroll at a health center, rather than to use more expensive, but less comprehensive, hospital emergency rooms and outpatient departments. These perspectives may conflict, particularly if costs for Medicaid agencies continue to increase, and if the agencies do not believe that the program is building service capacity for Medicaid recipients. ***As FQHC reimbursement systems become more stable over time, the interaction of the FQHC program and improved services for Medicaid patients should be carefully examined.***

B. WHAT HAS BEEN THE EARLY EXPERIENCE WITH IMPLEMENTING THE NEW PAYMENT SYSTEMS?

Implementation of the FQHC program at the study centers proceeded fairly smoothly, even at sites that lacked highly trained financial staff. In large part, we attribute the smooth implementation to the training provided through the Primary Care Associations (PCAs), which helped to prepare centers for an unfamiliar process. However, note that we base this conclusion on the experience of a few successful states and centers. Thus, although the centers in this study did not suggest a need for additional implementation assistance, it is possible that the universe of C/MHCs might require more aid than provided by the PCAs.

The process of developing payment methodologies at the state level included all parties--Medicaid, PCAs, and individual centers--in a relatively open atmosphere, in which discussion and involvement were typically welcome.- In most states, the PCAs took the lead in representing the health centers' interests. With some instances of friction, issues relating to the treatment of specific costs appear to have been resolved through discussion and negotiation. The factors contributing to this smooth process varied among the states and included:

- Support of (or, at least, lack of resistance to) the FQHC program on the part of state Medicaid agencies
- A belief on the part of the Medicaid agencies that the FQHC would have a minor impact on total Medicaid spending
- Expertise and knowledge made available by the PCAs
- Previous discussions of C/MHC reimbursement issues and prior relationships developed between Medicaid and the PCAs

Following the initial implementation, the state Medicaid agencies continue to grapple with management problems, such as the need for considerable staff resources to handle the retroactive reconciliation process. Some centers are experiencing extended payment delays, and specific payment

policies (such as whether to allow a particular cost to be included in the rates) continue to be debated.

Virtually all of ***the states cite the lack of*** **regulations** *from* ***the Health Care Financing Administration (HCFA) as the single more important problem in implementation.*** Without clear guidance from HCFA, the states were forced to determine the most appropriate methodologies to implement the requirement that payments be "based upon, and cover the reasonable costs of providing services to Medicaid beneficiaries." As a result, the states clearly believed themselves to be at some risk, as HCFA might conceivably adopt regulations to exclude certain aspects of their methodologies, possibly resulting in disallowances of federal matching payments to the state Medicaid programs. Some states adopted fairly simple rules, which were based on the use of previously approved cost reports. These states did so, in part, in order to remain flexible, in adapting to any new rules HCFA might later promulgate.

Expanding the FQHC program to include Medicare in OBRA-90 complicated and slowed the process of developing implementation rules for Medicaid. Medicare regulations were issued in June of 1992, while this report was being finalized. The Medicare rules are based on the RHC methodology and screens for reasonableness. They also establish payment limits for Medicare-covered services (a core package of Medicaid and preventive services) of $62.25 for rural centers and $72.39 for urban centers. These limits apply to services that are provided between October and December of 1991. They will be adjusted annually by the change in the Medicare Economic Index applicable to primary care physician services ***(Federal Register*, 1992).**

The implications of the Medicare rules for eventual Medicaid regulation remain unclear. The absence of Federal regulations has resulted in a patchwork of varying payment methodologies for implementing the FQHC program. Although all six study states had established all-inclusive payment rates, most also pay for some services that are not included in that rate. Maryland has separate rates

for dental services and add-ons for obstetrics. Centers in Rhode Island and Illinois bill for obstetrics separately. In Texas, Family planning, EPSDT, and pharmacy are paid separately. In addition,

- Three of the states used the FFHC cost report, and three use the RHC model.
- Two states established prospective-payment systems with no reconciliation, whereas the other four use all-inclusive rates with a reconciliation.
- Two states apply limits on administrative/overhead costs. One uses a complex system of screens. Three established overall limits on payments, and three did not.

Federal Medicaid rules must account for the unique payment methodologies that have evolved during the past two years. On the one hand, greater uniformity would make it easier for the Bureau of Health Care Delivery and Assistance (BHCDA) to compare the experiences of centers in different states.' On the other hand, changes in established methodologies in some states are likely to create new issues and problems, thereby extending the transitional period of implementation.

C. WHAT IS THE REVENUE EFFECT OF FQHC?

For some centers, FQHC appears to be having an impressive effect on Medicaid revenues. Of nine centers in this study, one center experienced a decrease in actual Medicaid revenues received, but the others have seen an increase between 1989 and 1991 which-ranged from 72 to 339 percent. When reconciliations for the year are finalized, the increases will be even larger. For example, the one center experiencing a decrease should received 50 percent more in Medicaid revenue than it did for the calendar year 1989; one Texas center has a project nine-fold increase.

At the same time, ***the experience to date is insufficient to permit assessment of the long-term revenue effect of the FQHC program.*** On the one hand, some centers have received first-year reconciliations for 1990, which are included in their reported revenues for 1991. In the future, as reimbursement rates are to be set closer to actual costs, these centers might receive lower cash revenues from Medicaid. In other cases, the full impact of FQHC has not yet shown up. Some centers are owed

substantial lump-sum payments, either because the reconciliation process has been delayed or because state payments have lagged considerably.

To appropriately account for retroactive payments, these revenues should be attributed to the year in which services were rendered. Current BHCDA reporting on the BCRR calls for annual reporting of actual receipts, regardless of the year in which services were rendered. ***BHCDA needs to be able to disaggregate retroactive payments*** *from* ***total Medicaid revenues in order to accurately monitor trends in Medicaid revenues under the FQHC program.***

Even after the transitional period is completed, documenting the impact of FQHC cost-based rates will be complicated. Expansions in Medicaid eligibility and covered services can be expected to increase revenues, irrespective of changes in payment rates. Three major improvements in Medicaid--improved eligibility for children, expanded services covered under EPSDT, and outstationing of eligibility workers at C/MHCs and disproportionate-share hospitals--were adopted and implemented at about the same time as the FQHC program. Understanding the effect of cost-based reimbursement alone requires a model that separates (1) enrollment increases, (2) intensity effects (more visits per patient), (3) case-mix effects (different services received by patients, and (4) revenue effects (higher rates per visit). This analytic task is complicated and might be best addressed through a one-time evaluation.

Differences in the definitions of key terms might limit the on-going monitoring of trends in Medicaid revenues to C/MHCs under the FQHC program. The state Medicaid programs define an "encounter" under FQHC to include all covered services rendered during a single visit to a health center. This definition differs from that used by most Medicaid programs prior to FQHC, when centers billed for each procedure. Equally important to BHCDA, if not more so, the Medicaid definition of an encounter differs from that used to collect annual data on the C/MHC program. The current BHCDA definition permits the recording of multiple encounters, each with a different provider, during a single visit. ***Improved data on Medicaid utilization and methods of addressing these***

disparate definitions, will be needed if trends in Medicaid revenues and the effect of the FQHC program are to be understood.

Although the overall revenue impact of FQHC is far from clear at this time, states are evidently concerned about the cost implications. To some extent, these concerns reflect a prevailing view that cost-based reimbursement encourages inefficiency. However, they also reflect the fact that the cost-based rates are substantially higher than previous payment rates, and that expenditures for C/MHC services are likely to increase substantially. Some states, concerned about the potential budgetary impact, appear to be skeptical about the program. Careful consideration of the comments provided by state agencies during this study suggests the following:

- ***State agencies are looking at FQHC in isolation.*** Although the FQHC revenue increases appear (and are) substantial, payments to these programs still represent a very minor part of total Medicaid spending. For instance, in Texas, payments to C/MHCs rose from about $1 million to $4 million. However, these expenditures amount to only 0.7 percent of total Medicaid spending on physician services, and an almost infintessimal portion of the $4 billion total Medicaid budget.

- ***State agencies are concerned about the potential long-term impact of "look-alikes."*** Although the level of concern about look-alikes differs among respondents, some states were clearly aware of the growing number of look-alikes and of issues surrounding the extent to which waivers should be provided. Illinois, in which the majority of FQHC centers are look-alikes, specifically mentioned the reported increase in spending on look-alikes as an issue.

Addressing these concerns calls for careful analyses that are beyond the scope of this study. In some states, the FQHC program has resulted in a shift of expenditures from one line of the Medicaid budget to another. For instance, in Illinois, centers that were previously reimbursed as "physician services" are now being paid as "community health centers." This shift, coupled with the large number of look-alikes in that state, partly accounts for the cited increase in spending in the "community health center" line, from $6 million to more than $50 million.

Questions about look-alikes raise an entirely separate set of issues, such as standards for the two-year waivers, and whether monitoring of approved centers should be on-going. Although this study

included one look-alike center, that particular center required no waivers for qualification, and its experiences were not applicable to the larger issues currently being discussed.

D. HOW ARE CENTERS USING FQHC-GENERATED REVENUES?

Centers appear to be using FQHC revenues to meet urgent needs that have accumulated as a backlog of unfunded priorities over time. ***These funds are being used primarily to improve the basic infrastructure for expanding service delivery capacity.*** In making these choices, centers have looked at the needs of both their current catchment areas and their surrounding communities. Two centers have used FQHC-generated revenues to start new satellite sites, and two more are considering initiating such services.

One might say that the centers view their FQHC-generated revenues as an opportunity to invest in the future. There is an implicit hierarchy to these investment decisions:

- ***Building construction and renovation to provide more practice suites and related administrative and service areas.*** Almost all of the centers were operating under severe space constraints, which inherently limited their abilities to improve or expand services. Two of the nine sites are being forced to replace their buildings.

- Increase ***staff (physicians and mid-levels), particularly in the high-demand specialties of pediatrics and perinatal care.*** At least five of the centers have had systematic difficulties filling staff vacancies. FQHC revenueshave offered the possibility of improving compensation, in order to compete for' talent and skills and, equally important, to retain essential medical staff.

- ***Identify service gaps and purchase necessary equipment and/or hire staff to provide these services.***

When the FQHC legislation was first enacted, some officials expressed concern that the centers might adapt poorly to the new financial environment. It was unclear whether centers would be able to respond in a timely and judicious manner to cost-accounting requirements. In addition, there was some concern about how centers would respond to a sudden jump in lump-sum reimbursements. For example, would they rapidly develop specific service expansions that might not be financially viable over the long term?

We found that the visited centers have diligently prepared for FQHC implementation, and that they have allocated their revenues prudently. Most of the centers had already developed formal or informal strategic plans, which identified major needs and future directions. These centers are investing their FQHC dollars in the physical plant and staff required to provide basic and comprehensive primary care services to their communities.

To some extent, the current state of FQHC implementation may encourage centers to use FQHC-generated funds for one-time expenditures. Spending plans may reflect the transition period, with its sizable retroactive reconciliations. The reality is that lump-sum payments, which are not tied to immediate service costs, are in many respects like a grant. As such, they are easily allocated to capital and equipment expenses. Moreover, BHCDA policy encourages the use of unanticipated revenues for capital improvements and other non-recurring expenditures.' In the future, centers are likely to bill for, and to receive, reimbursements that are closer to current Medicaid service costs. At that time, expenditure patterns may change.

The centers are skeptical about the long-term future of FQHC, which also affects their decisions on the use of revenues. Factors promoting skepticism include:

- Slow and irregular payments in some states
- Delayed reconciliations, which leave centers at risk of having to pay back funds to the state
- State budget crises, which lead to the feeling that the program may become a target for budget reductions
- Concern about the interrelationship of higher FQHC revenues and levels of future BHCDA grant funding

[1]Excess program income occurs when a center collects more third party revenue than originally projects in its budget for a particular year. The Public Health Service Act seeks to encourage maximization of third party revenue by providing that such unanticipated revenue increases will not be offset against the BHCDA grant. If more than 50 percent of such revenues are spent on capital improvements prior approval from the BHCDA regional office is required.

These concerns will most likely continue to be issues as the program is implemented. Although BHCDA has clearly stated, in its recurrent cost policy, that revenues directed to expanding or improving patient services will not be offset against grant funds, these issues continue to concern the centers.[2] There may be some confusion, or apprehension over application of these policies. The recent General Accounting Office report, which specifically criticizes the application of this policy to FQHC revenues, can only add fuel to these concerns (GAO, 1992).

The centers and BHCDA will need to adapt to the new fiscal management demands generated by the FQHC. Cost-based reimbursement carries with it the potential of lump-sum payments--and of lump-sum pay-backs to the states. This environment calls for practices that are associated more frequently with business management than with the management of non-profit, grant-centered organizations. For example, prudent management might call for husbanding some resources in reserves, to ensure the availability of funds to cover pay-backs resulting from reconciliations. Construction and renovation plans cannot be implemented overnight, and centers might need retain part of thejr FQHC revenues to pay for these later costs. BHCDA is developing a policy which addresses these short-term uses of funds. More ***clarification and guidance to the centers on the treatment of FQHC-generated revenues may be in order.***

Over the long term, the success of the FQHC program will be judged not merely by its ability to generate Medicaid revenues, but by its impact on access and services for medically underserved populations. Partly as a result of a transition period, FQHC-generated revenues yield large lump-sum Medicaid payments. As Medicaid revenues begin to flow more smoothly, the impact of FQHC can be expected to influence the treatment of the BHCDA grant, which can be redirected to provide care for more patients or to establish new services.

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[2] In preparing grant applications, centers report total costs and anticipated revenues; the grant request represents the difference. Under FQHC, revenues will rise as Medicaid rates increase. BHCDA has stated that projected FQHC revenue increases will not result in reduced grants, provided that expenditures are directed into recurring costs related to expanding services or patient caseloads and that BHCDA gives prior approval for the proposed expenditures. The GAO report criticized this policy.

A mechanism for documenting effects on patient care will be needed both to facilitate BHCDA grants management and to monitor the long-range impact of the FQHC program. Such information could be requested as part of a center's grant application or as a separate report. Whatever mechanism is developed, information should be collected on:

- Expansion of caseloads (for example, initiating outreach to target populations)
- Addition of new services (for example, initiating physical therapy)
- Expansion of existing services (for example, adding another physician, or the ability to perform more complicated tests)
- Operational improvement (for example, increased administrative staff, or higher salaries)
- Capital improvements

APPENDIX A

CENTER PROFILES--FQHC **REVENUE** ALLOCATION PLANS

CAIRO. This center serves the rural community in its immediate environs in two counties. This service area is very poor, having the highest proportion of Department of Public Aid families of any of the study sites. The economy of the community is depressed, the 1991 unemployment rate having reached. nearly 18 percent. The center is the oldest in the study cohort and was established in 1974. According to 1990 BCRR data, it also had the highest proportion of Medicaid revenue, with nearly 33 percent of its total revenues derived from this source. The center operates a satellite site and had a 1990 total of almost 5,800 medical users. The announcement of FQHC reimbursement did not generate additional planning activities by the center's Board, but was seen as a means to accelerate the achievement of already established goals. The executive director commented, "We always had a five-year strategic plan; the question was how to get there." The immediate uses of the FQHC funds included:

- ***Establishing a New Main Clinic Site.*** According to the center's key administrative and medical staff, "the building projects couldn't have been done without FQHC and other cost-based encounter rate programs such as FFHC." FQHC reimbursement was instrumental in securing the "megaclinic" financing through local and regional banks, approximately $850,000 of the total $1.2 million construction cost. Approximately two-thirdsof the patients of the new megaclinic site are expected to be covered by Medicaid.

- ***Establishing a Satellite Site.*** A new satellite clinic was established with FQHC funds. About $100,000 was put into construction for this new site.

- ***Re-establishing Obstetrical Care.*** FQHC revenue is used to offset the expense of two part-time obstetricians, who alternate one day per week at the main clinic, and a nurse practitioner specialist in obstetrics. These professionals anchor the center's prenatal program and reestablished its commitment to family planning and well-woman care.

- ***Improving Provider Compensation Packages.*** According to the executive director, FQHC reimbursement has also lead to "dramatically improved provider compensation packages." He cited the ability to present a strong financial position, which FQHC represents, "as the key to retaining providers."

CENTREVILLE. This center is a seven-year-old midwestem urban CHC founded by a local philanthropist. It serves one of the poorest areas in the nation. In 1990 the center had 4 physicians

and a staff of 23 who were responsible for slightly fewer than 20,000 medical care encounters. Between 1990 and 1992, the number of medical users increased from a little more than 3,000 to almost 5,000. The center's commitment to a coordinated and comprehensive approach to health care delivery is demonstrated by involvement in several networking and planning activities with other community providers and by its involvement in such other community efforts as task forces on infant mortality, substance abuse, and housing. The center is acknowledged by local community and medical leadership as a major force in coordinating all outpatient services in an area where health care needs have been documented to be most desperate.

The center's Board understood that cost-based reimbursement would mean a significant influx of funds and decided to put the majority of the funds into nonrecurring costs, specifically, into "building the health infrastructure." The announcement of FQHC cost-based reimbursement did not generate a call for additional planning activities; the needs of the CHC and the community were clearly known. The specific contributions that FQHC reimbursement is making to the CHC's goals and mission include:

- ***Establishing a New Satellite Facility.*** According to the center's chairman of the Board, the community "had a vision of a new health center [in the community] since about 1986 and FQHC is making it happen." The satellite site was established in an area that had a health clinic that closed in the early 1980s, having fallen victim to widespread corruption, administrative incompetence, and the general socioeconomic decline of the entire community. The ribbon-cutting ceremony for the new site took place on June 10, 1992.

- ***Establishing a Financial Incentive Program for Providers and Other Staff.*** In 1991, FQHC reimbursement permitted the center to make a modest salary adjustment (2 percent) for all nonphysician staff. In addition, a "bonus productivity plan" was instituted: when certain ratios of encounters to providers are exceeded, the staff receives a modest bonus. The bonus program will be in effect for as long as the current FQHC encounter rate is in effect. If the encounter rate decreases, then the bonus will not be given. Also, as provider contracts were renegotiated, the center was able to include salary increases that made salaries more competitive with those of other community providers.

- ***Purchasing a New Computer System That Will Improve Patient Tracking. The*** Board approved the purchase of a computer system that tracks patient life cycle with the FQHC funds.

The executive director noted that FQHC will probably have its greatest long-term impact on the private provider relationships and on the center's commitment to a coordinated and comprehensive health care delivery system for the community. FQHC allows his center to "buy private providers into the system." For example, the center first refers patients to the private providers and allows other community physicians to moonlight in the center and share calls with the center's staff. In this way, according to the executive director, FQHC is being used as a "catalyst to build up the [CHC] clinic." He further noted that cost-based reimbursement is important to attracting and keeping providers in the community by enabling a CHC to be competitive in terms of salary. However, he cautioned the center to do careful strategic planning, saying "FQHC is not a quick fix; increased funds do not substitute for good planning."

BALTIMORE. The Baltimore site, People's Community Health Center, exemplifies an urban health center that does not receive 330 grants and has had difficulty stretching available resources to meet critical primary care needs in the city since 1970. As the first approved FQHC "look-alike," it recognized the importance of FQHC for maintaining financial viability. The Baltimore center also seeks to position itself as a key inner-city Medicaid provider under the new Maryland Managed Access to Care (MAC). program while continuing to serve low-income uninsured families.

While rich in history and community support, the Baltimore center facilities and equipment can neither adequately meet the community's primary care needs nor ensure quality of care. Without increased Medicaid payments, the center's financial situation would have been precarious since it depends on unstable sources of funding such as small grants, donations, and patient fees.

FQHC revenues will be used in large measure to improve access, scope of services, and quality of care. FQHC investment priorities include:

- Renovating clinic facilities and increasing the number of practice suites to accommodate additional professional staff. Renovations will include a new roof and the power lines needed for additional medical equipment and computing systems.

- Recruiting an obstetrician for more extensive on-site hours for prenatal care, and recruiting- other staff. Over the past several years, tight budgets precluded replacing professional and support staff.
- Upgrading diagnostic and screening equipment, most of which was donated and is quite old.
- Upgrading data management and billing systems (hardware and software).

PROVIDENCE. The Providence center consists of five community health centers, a high school clinic program, and a STD clinic (operated under contract with the Rhode Island Health Department). The caseload has remained stable in recent years. The Providence centers serve a diverse, multi-racial and ethnic population. Over 50 percent of the patients either do not speak English or have only limited English language skills. Each of the sites has culturally appropriate bilingual staff (for example, Hispanic, Cambodian, Hmong, Laotian). The patient mix is skewed: two-thirds are female; over half are younger than 20 years of age; and the largest single group is Hispanic women of child-bearing age.

There has been a 25 percent increase in Medicaid patients since 1990. The majority of them had been Providence patients before becoming Medicaid eligible through the mandated expansions for pregnant women and children. Others have become income eligible as a result of the severe recession in New England.

For FY 1992, Medicaid accounts for 23.6 percent of budgeted revenues but 38 percent of Providence's caseload. Over the past three years, Medicaid revenues have increased substantially, rising by 53 percent in 1991 and by 40 percent in 1992. As noted, Medicaid revenues in Rhode Island must be tracked by comparing billings and payments, since there continues to be a considerable time lag in the CHC's actual receipt of FQHC payments. For Providence, the shortfall in actual FQHC payments is substantial--approximately $1 million cumulative. If the cash-flow situation does not improve, Providence Ambulatory Health Care Foundation may forced to consider temporary lay-offs.

In anticipation of FQHC payments, Providence's budget includes the projected $1 million for Medicaid receivables. These funds have been allocated to:

- Staff increases, including ten nurses, one obstetrician, and one pediatrician.
- Compensation-related costs--health insurance premiums (rose by 40 percent) and malpractice insurance costs (premiums and mandated contribution to the Rhode Island Stabilization Reserve Fund).

Priority areas for service delivery capacity expansion include the following:

- Changing the staffing mix by increasing the number of family practitioners and mid-level professionals (for example, nurse practitioners). Recruiting additional staff will help to reduce the waiting period for appointments. There is now a three- to six-month wait for preventive care appointments and a one-year wait for dental appointments.
- Purchasing vans for transportation services to address the missed-appointments problem (currently 35 percent) and to improve continuity of care.
- Expanding center hours.
- Obtaining foundation grant for a hepatitis B vaccine program, targeting at-risk children as recommended by CDC. Hepatitis B is problem among Southeast Asians, particularly among the children of newly arriving immigrants in the Providence area.

Thus far, the anticipation of FQHC revenues has resulted in some staff increases, but further staffing and service expansions will not occur until the state Medicaid agency covers its backlog in FQHC payments.

DALLAS. The Dallas center, Martin Luther King, Jr. Family Clinic, is located in a low-income, predominantly African-American neighborhood. The center operates a full-service medical clinic, which includes dental and some laboratory facilities, and a part-time school-based clinic. The center is housed in a city-owned multipurpose complex that also includes legal services, social services, a public library, a child care center, and a recreation center. It shares part of its space with the Dallas City Health Department.

FQHC has led to significant increases in revenue at the center. In 1991, it received $373,428--an amount well above the 1989 Medicaid revenues of slightly under $85,000. Of this amount, $184,000 was a lump sum reconciliation payment applicable to services rendered in 1990.

The Dallas center has been somewhat reluctant to commit funds to adding services until total Medicaid revenues have stabilized and the transition period is over. This reluctance stems, in part, from the uncertainty about the long-term future of FQHC. In addition, this is the first time in several years that the center has been fully staffed with physicians. The executive director anticipates a tight budget and indicated that the funds from the first reconciliation may need to be used to support operating costs.

For the future, Dallas sees the following areas as priorities for potential use of FQHC funds:

- Establishing a satellite clinic at a nearby public housing project
- Improving compensation for all staff
- Renovating and expanding the facility particularly if the City Health Department moves its program out of the current facility
- Upgrading x-ray facilities to eliminate the need to refer patients to Parkland Hospital
- Developing a mobile unit for child immunizations in the community

EAGLE PASS. United Medical Center in Eagle Pass is the primary provider of health care to low-income and uninsured residents in three rural counties in southwestern Texas. Over the past decade, both caseload and services have expanded substantially. Eagle Pass provides services in three counties; the primary facility includes a main clinic building and some specialized services; administrative offices are located in near-by buildings. Eagle Pass's current space severely circumscribes its service delivery capacity. For example, the center cannot accommodate more physicians to address primary care needs, and it is even in danger of losing its current space. One

of its buildings is located on the site of a proposed international bridge, while the hospital that owns the main clinic building has indicated it may wish to repossess the site.

Prior to FQHC, Eagle Pass received an average of $14 per encounter from Medicaid. Eagle Pass's 1990 Medicaid revenues were under 5 percent of total revenues ($4.2 million). With FQHC, payments have increased to $74.41 per encounter. Thus, FQHC will be a more significant source of revenues even if the number of Medicaid users does not rise.

Eagle Pass did not initiate a FQHC strategic planning process to review options for allocating anticipated revenues. The Board had recently identified the very obvious space problems and other opportunities to improve service delivery capacity. Current plans for allocating FQHC revenues include:

- Constructing of a 30,000-square-foot building. The estimated cost is $1.5 million. It is projected that the first two cost settlements will be sufficient to cover almost half of the estimated construction costs. UMC also plans to solicit matching funds from foundations to cover the remaining costs.
- Improving compensation in order to attract and retain physicians and other valued staff. UMC physicians' salaries are substantially below the market, and thus, it has proven difficult to attract qualified professionals to rural border communities. Recruitment efforts will also target specialists (for example, nutritionists, psychologists, occupational therapists) and thus permit the expansion of services.

Eagle Pass is also exploring strategies for expanding its service areas to include neighboring underserved counties. This review is in its early stages; there are no firm decisions or plans for new sites.

AXTON. The Axton center is a relatively small clinic serving a rural population in southern Virginia. Caseloads have steadily grown over the past several years. Medicaid, however, remains a comparatively small percentage of its revenues (less than 7 percent in 1990). This center's modern facilities were expanded two years ago to provide space for offices and additional treatment suites. Recruiting and retaining physicians has occasionally proven to be a problem.

Axton is using first-year FQHC revenues to fill critical service delivery gaps.

- High priority was given to recruiting a second physician. Danville Memorial Hospital contributed $22,000 that supplemented the FQHC set-aside of $15,000.
- Funds have been set aside for purchasing medical equipment--a cast saw for treating broken bones and a QBC-II machine for blood tests. This equipment permits Axton to provide timely and convenient access rather than having to refer patients.
- Consistent with its fiscally conservative philosophy, Axton also set aside approximately $9,000 for first-year implementation of Medicare-FQHC. Center staff anticipated transition Medicare-FQHC payment lags, and a modest reserve will bridge any Medicare cash-flow problems.

MILWAUKEE. The Milwaukee center serves a Hispanic community--largely low-income and indigent. Prior to FQHC, Medicaid accounted for 11.5 percent of total revenues. With FQHC, estimated Medicaid revenues will rise by approximately $300,000, accounting for 21 percent of the projected annual revenues. This rise in Medicaid revenues is attributable to both FQHC and Medicaid eligibility expansions.

The Milwaukee center occupies a renovated building purchased with a 1984 BHCDA grant. The renovation loan was paid off in 1990. The Board recently approved plans to further expand the facility so that it will accommodate rapid growth in the caseload and volume of services that has occurred over the past few years. For example, primary care encounters have risen by 50 percent since 1988. Since demand is outstripping capacity, the number of Medicaid HMO patients that can be enrolled has been restricted.

Milwaukee's plans for FQHC revenues have been on the drawing board for several years. FQHC provides a much needed source of funds for expanding the center so that it may meet the demand for services. Priorities include the following:

- Plans for expansion include construction costs of $657,000 and related staffing costs of $99,220 (two full-time RNs and two full-time medical assistants).

- Physician recruitment efforts and/or improved compensation package to attract and retain staff. Options are under review. Turnover has been a problem over the past several years, and recruitment and retention are therefore critical.

- Consideration is also being given to pooling of FQHC funds by several area centers to recruit an obstetrician or to contract for obstetrical services. As in other communities, attracting prenatal care providers has proven most difficult and expensive.

MINONG. This center, located in a rural community in the Midwest, has its roots in a rural health cooperative. The main clinic site and its two satellites serve patients from a six-county area, including the land of Native Americans. The local economy depends on logging, fishing, and tourism. This center is the smallest of the study sites, with 1990 BCRR data revealing 3,658 medical users, 2.2 primary care FTEs, and 9,345 primary care encounters. The center also had the lowest proportion (5.2 percent) of total revenues attributable to Medicaid collections.

The primary target for FQHC Medicaid funds was the expansion of CHC services to an area identified for future growth during a two-year strategic planning process that was completed in 1990. Specific immediate uses of the new funds include:

- Establishing a satellite site that includes all the basic services provided at the main clinic site, including primary physician care; 24-hour telephone access; and ensured access to lab, pharmacy, and x-ray services. The site is about 50 miles from the closest interstate, and the two closest metropolitan cities are 115 miles and 60 miles away. About half of the additional revenues generated as a result of FQHC Medicaid implementation was used to renovate the satellite clinic building.

- Acquiring x-ray and other needed equipment for the satellite site. The nearest x-ray facilities are 20 to 30 miles from the new clinic site. The balance of the first-year FQHC funds was targeted for these purchases.

- Recruiting a physician to staff the new satellite clinic and to re-institute services to the Native American clinic that had lost all access to primary physician care with the loss of doctors from a private group practice in the county. No other health care providers are based within a 20-mile radius of the satellite site, and the nearest providers have become increasingly reluctant to accept Medicaid patients.

Continued FQHC reimbursement in the long term, according to the center's medical director, will exert "a larger regional influence on health care in the area by helping [the CHC] to improve the

scope of services available to area residents; provide long-term support of other regional health care providers who are no longer able to accept Medicaid, Medicare, and uninsured patients; develop as a resource to other regional health care providers; and expand the availability of mental health and social work services."

APPENDIX B

SITE VISIT PROTOCOLS

1. STATE PRIMARY CARE ASSOCIATION

INTERVIEW PROTOCOL

STATE PRIMARY CARE ASSOCIATION
INTERVIEW PROTOCOL

STATE: _____ INTERVIEWER: _____ DATE: _____

INTERVIEWEE (Name/Title): _____

ADDRESS: _____

TELEPHONE: _____

FOLLOW-UP NOTES:

A. BACKGROUND ON FQHC IMPLEMENTATION

1. Please tell us about the process of implementing FQHC. Who were the key players in developing the reimbursement policy?

2. How did your counterpart (PCA or Medicaid agency) view FQHC? How would you describe the process of developing the reimbursement policy?

3. Were there any particular issues that presented a potentially serious problem? How were they resolved?

4. How would you characterize the objectives of FQHC in your state? (e.g. improving access for Medicaid patients; increasing reimbursement and Medicaid payments)

5. What is your assessment of the new FQHC rate-setting methodology? What are its strengths? Weaknesses? And, how does it compare with the conventional Medicaid reimbursement system?

6. What changes, if any, would you propose for the FQHC payment methodology? Why?

7. Medicaid budgets in most states are under serious review. In your state's review of Medicaid program policies and budget, have the FQHC provisions been subjected to special scrutiny?

8. Are there any modifications in the State's FQHC payment methodogy now proposed? Are there issues which need to be address (e.g. definition of "covered services"; reimbursement for CHCs participating in Medicaid managed care programs)?

9. Based on your experiences in FQHC negotiations, what--if anything--would you do differently if you had an opportunity to start anew?

10. How did the fact that HCFA had not issued regulations on Medicaid-FQHC affect the development of FQHC payment methods?

11. To what extent were individual C/MHCs involved in discussions on the state's FQHC policy and implementation process?

12. Was [center we are visiting] involved? How would you describe its contribution?

13. Did the National Association of Community Health Centers provide technical assistance and/or guidance in the early stages of the state's FQHC implementation process? If yes, please describe.

B. FQHC **RATE-SETTING** METHODOLOGY

1. We sent you information summarizing the status of FQHC and the methodology in your state, as we understand it. We would like to review this with you in order to confirm accuracy and completeness.

2. We are particularly interested in understanding the process and timing for filing cost reports. Please describe this for us. We would also like to know:

   - Is the cost report process used to set next year's rates?
   - Is this an "end-of-year" reconciliation (e.g. a means of balancing Medicaid revenues received by a center during the year with actual costs)?
   - IF Yes, how do you adjust for over/under payments? Are excess payments due in a "lump sum", over time, or deducted from the following year's rate?

     Are there any limits on the amount/percent the center must pay back at one time?
   - Are centers seeking technical assistance or consultant services (e.g., accounting) in the reconciliation process?

3. Have cost reports been filed? Have end-year reconciliations occured yet? If not, when will reconciliations begin?

   - If yes, what was the result? How many centers receive funds and how many are slated to pay back due to excess first year revenues?

   - How would you describe the ability of the C/MHCs in preparing their initial set of cost reports?

4. IF THE STATE DID NOT BEGIN FQHC PAYMENT AS OF APRIL 1990, is there a policy regarding retroactive payments for centers that were not receiving FQHC payments as of April 1990? How does the state plan to handle the time lag between mandated implementation and actual flow of FQHC dollars?

C. CURRENT STATUS AND FUTURE IMPLICATIONS

1. How many C/MHCs are billing under FQHC? Is this all centers?

   · IF ALL CENTERS ARE NOT BILLING, do you know why they have chosen not to bill under FQHC payments?

2. Have any "look-alikes" been approved? How many? Are they community clinics; health department clinic; other?

3. Were any of the FQHCs previously receiving cost-based payments as Rural Health Clinics or Federally-funded Health Centers? How many?

4. Are there any significant implementation problems surfacing (e.g. delays in receiving payment)?

5. Has your organization assessed the fiscal impact of FQHC thus far? If yes, what are the preliminary findings?

D. SITE VISIT PREPARATION

As you know, we are visiting [NAME OF C/MHC]. Can you provide us with additional information on the center, such as:

   - Is this center representative of C/MHCs in your state?

- Do you know of particular problems/issues regarding FQHC at this center?
- What more can you tell us about their expansion plans?

2. STATE MEDICAID AGENCY

INTERVIEW PROTOCOL

STATE MEDICAID AGENCY
INTERVIEW PROTOCOL

STATE: _____ INTERVIEWER: _____ DATE: _____

INTERVIEWEE (Name/Title): _____

ADDRESS: _____

TELEPHONE: _____

FOLLOW-UP NOTES:

A. BACKGROUND ON FQHC IMPLEMENTATION

1. Please tell us about the process of implementing FQHC. Who were the key players in developing the reimbursement policy?

2. How did your counterpart (PCA or Medicaid agency) view FQHC? How would you describe the process of developing the reimbursement policy?

3. Were there any particular issues that presented a potentially serious problem? How were they resolved?

4. How would you characterize the objectives of FQHC in your state? (e.g. improving access for Medicaid patients; increasing reimbursement and Medicaid payments)

5. What is your assessment of the new FQHC rate-setting methodology? What are its strengths? Weaknesses? And, how does it compare with the conventional Medicaid reimbursement system?

6. What changes, if any, would you propose for the FQHC payment methodology? Why?

7. Medicaid budgets in most states are under serious review. In your state's review of Medicaid program policies and budget, have the FQHC provisions been subjected to special scrutiny?

8. Are there any modifications in the State's FQHC payment methodogy now proposed? Are there issues which need to be address (e.g. definition of "covered services"; reimbursement for CHCs participating in Medicaid managed care programs)?

9. Based on your experiences in FQHC negotiations, what--if anything--would you do differently if you had an opportunity to start anew?

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1. We sent you information summarizing the status of FQHC and the methodology in your state, as we understand it. We would like to review this with you in order to confirm accuracy and completeness.

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   - IF Yes, how do you adjust for over/under payments? Are excess payments due in a "lump sum", over time, or deducted from the following year's rate?

     Are there any limits on the amount/percent the center must pay back at one time?

   - Are centers seeking technical assistance or consultant services (e.g., accounting) in the reconciliation process?

3. Have cost reports been filed? Have end-year reconciliations occured yet? If not, when will reconciliations begin?

   - If yes, what was the result? How many centers receive funds and how many are slated to pay back due to excess first year revenues?

   - **How would you describe the ability of the C/MHCs in preparing their initial set of** cost reports?

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   - IF ALL CENTERS ARE NOT BILLING, do you know why they have chosen not to bill under FQHC payments?

2. Have any "look-alikes" been approved? How many? Are they community clinics; health department clinic; other?

3. Were any of the FQHCs previously receiving cost-based payments as Rural Health Clinics or Federally-funded Health Centers? How many?

4. Are there any significant implementation problems surfacing (e.g. delays in receiving payment)?

5. Has your organization assessed the fiscal impact of FQHC thus Ear? If yes, what are the preliminary findings?

3. HEALTH CENTER DISCUSSION GUIDE

SITE VISIT DISCUSSION GUIDE

A. CENTER BACKGROUND/ENVIRONMENT [EXECUTIVE DIRECTOR, BOARD CHAIR]

1. As an introduction to your center, please tell us a little about this community?

   - What are community's most pressing health care needs?
   - Who are the other major providers that serve Medicaid clients? Indigent patients?
   - What are the major problems Medicaid and indigent clients have in obtaining access to care?

2. We would like to know about the history of this center. How did it start'! What is your defined service area? How would you characterize your mission, and has it changed over the years? What are the characteristics of your patients (e.g. age, insurance/sliding fee scale).

3. In the two years before FQHC, were your Medicaid users increasing? Why (e.g. Medicaid eligibility improvements)? Were these patients previously using the center or new Medicaid users?

4. Do you have on-site Medicaid eligibility determination capacity (i.e., outstationing)? If yes, what has been your experience (e.g. increase in Medicaid enrollees; experience in expedited determinations)?

5. Please describe your services prior to implementation of FQHC. What are your hours of operation? [The table on the following page lists the types of services in which we are interested.]

6. Prior to FQHC (or during the past 2-3 years) did you make any significant changes in services or operations? (e.g. expand hours; drop a service). Why?

7. What do you consider to be the strengths (or weaknesses) of this center?

8. How would you describe your most pressing needs at this time (e.g. recruitment, meeting expanded demand for services)?

9. Please describe the organizational structure. (Number and type of staff; Board structure).

TABLE 1

CENTER SERVICE AND DELIVERY SYSTEM
PRIOR TO IMPLEMENTATION OF FQHC
(Question A.5)

Service	Arrangements for Provision of Services				Number of Sites Offering Service
	Provided by Center Staff	Provided through Arrangement	Referral	Not Provided	
MANDATORY					
Primary Health					
laboratory					
X-ray					
Pharmacy					
Preventive Health					
Preventive Dental					
Emergency					
Transportation					
Case Management					
ADDITIONAL					
Prenatal Case Management					
HIV/AIDS Services					
Eligibility Determinations for Medicaid/WIC					
Other					

B. BACKGROUND ON FQHC IMPLEMENTATION [EXECUTIVE DIRECTOR, CFO/ACCOUNTANT, KEY FQHC STAFF]

1. What is your assessment of the new FQHC rate-setting methodology? Strengths? Weaknesses? What changes, if any, would you propose for the FQHC payment methodology? Why'?

2. How did you first learn about FQHC? Were you involved in negotiations or discussions about methodology?

3. Have any controversial issues surfaced, especially with regard to definition of "covered services" and/or specific services such as "case management" or "managed care"?

4. Since FQHC was implemented, are you trying to recruit more Medicaid patients or target on providing more Medicaid reimbursable services?

C. FQHC PREPARATORY ACTMTIES [EXECUTIVE DIRECTOR, CFO/ACCOUNTANT, KEY FQHC STAFF]

1. During first-year implementation, have there been any notable problems that required special attention? What was the nature of problem and resolutions, if any thus far?

   Examples of problems centers have had include:

   - Delays in receipt of the FQHC payments.
   - Problems in dealing with the Medicaid fiscal agent.
   - Problems in using new billing forms (eg. complexity; insufficient information).

2. What types of technical assistance and/or guidance did you receive in the early stages of FQHC implementation? From whom? (E.g. Primary Care Association, the National Association of Community Health Centers)

3. While experience is clearly limited, are you aware of any other implementation problems that warrant attention?

4. Some centers have found the preparation of cost reports to be a major hurdle. What has been your experience?

   · Had you done a cost report before?

   · Did you receive assistance/training in preparing the cost reports? What type of assistance?

- Did you hire any consultants or additional accounting help to assist in the cost review and preparation of the cost report?
- What difficulties did (do) you encounter with the cost reports?
- Do you think you are now adequately prepared for completing a second year cost report?

5. Did you make any changes in management, accounting or billing because of FQHC? Do you think you will need to make changes? Examples of changes include:
   - Automated billing system
   - New accounting system to segregate costs for cost reports

6. Does FQHC create need for new personnel or other new expenditures? How much has FQHC implementation cost you?

D. FQHC REVENUE IMPACT [EXECUTIVE DIRECTOR, CFO/ACCOUNTANT]

We want to understand the financial effect of FQHC on your center. Table 2 on the following page outlines summary information on FQHC implementation and revenues. The questions below expand on that information. Since payment methods under FQHC differ among the states, some may not apply to your situation.

1. Have you monitored changes in Medicaid revenues since implementation of FQHC? If yes, can you tell us the change in dollar amount over a specific period (e.g. 3 months).

2. **IF** Center has an all-inclusive rate:
   - Are all Medicaid services included in the FQHC payment? What services are billed to Medicaid outside of FQHC payments
   - Can you separate revenues for services in the FQHC rate and those billed separately? If so, can you give us an estimate of those revenues?

3. Have you projected Medicaid revenues for the next 2 years? What do you expect (e.g. increase/decrease)?

4. Has FQHC affected your total revenues (e.g. increase in dollars) and/or distribution (e.g. higher proportion from Medicaid)? How much?

5. Have you had a first-year cost reconciliation yet -- i.e. submitted a cost report, which the Medicaid program has audited to determine if Medicaid payments match your Medicaid costs under FQHC?

   - If not, when will reconciliations begin?
   - If yes, please describe the process?
   - What was the result? Payment to you by Medicaid? You owed Medicaid money? Increase or decrease in your FQHC payment rate?
   - If you are likely to owe Medicaid, do you anticipate having sufficient cash on hand for covering the excess payment?
   - What are your greatest concerns about this process?

6. For **multi-site centers:** Can you separate the new FQHC revenues by site?

TABLE 2

SUMMARY INFORMATION ON REVENUE EFFECT OF FQHC

Date of first billing under FQHC
Date of first FQHC payment
Approved FQHC rate
Total Medicaid revenues
• 1989 • 1990 • 1991
Effect of FQHC
Estimated Medicaid reimbursement per visit/encounter
• Without FQHC • With FQHC
Estimated total Medicaid revenues
• Without FQHC • With FQHC

E. USING FQHC REVENUES FOR SERVICE IMPROVEMENT AND EXPANSION [EXECUTIVE DIRECTOR; MEDICAL DIRECTOR; KEY BOARD MEMBERS AND OTHER KEY STAFF]

1 . Did you engage in a formal process to assess how much revenue FQHC might yield and how these funds might best be used for improving center operations and capacity?

2. Who are the key participants in the process? What major "expansion" and "improvement" areas were identified and why were they high priority?

3. How are you planning to use new revenues from FQHC? Examples might include:

- Start a new service
- Purchase equipment
- Building renovation
- Hire additional staff

4. We would like to get detailed information on each of the new activities you plan to implement with FQHC dollars. In addition to understanding **what** you are planning to do, we would like to know:

- Current status (e.g. planned/underway)
- Why you selected this particular expansion?
- Whether other options were considered? (e.g. establishing referral arrangements rather than adding a service)
- Did you do detailed estimates of costs, one-time start-up and on-going operations?

5. ***For FQHC-funded initiatives which have been implemented:***

- What has been the effect (change in caseloads, etc.)?
- What difficulties did you encounter in implementation?
- How are you monitoring implementation?

6. ***For multi-site centers:*** How do you address expansion needs of different sites?

7. Do you have a process/procedure for monitoring expenditures on a new project, to assure that estimates are not exceeded? Is there data and/or client information that would be useful in your strategic planning and implementation monitoring activities?

8. What lessons have been learned about expanding service with FQHC revenues'! What experiences would you like to share with CHCs as they adapt to the FQHC opportunities'!

4. Have you identified any special technical assistance (or other) needs in implementing service expansions?

F. LONGER-TERM POTENTIAL IMPLICATIONS OF FQHC [EXECUTIVE DIRECTOR: BOARD CHAIR; MEDICAL DIRECTOR]

1. What do you see as the long-term impact of FQHC on the center'! Do you have a multi-year strategy for using FQHC revenues?

2. Do you think FQHC will increase the number of Medicaid recipients using the ccntcr? If so, do you think this might affect your ability to serve uninsured and sliding fee patients?

3. If the state changes its FQHC payment method, how would this affect your service expansion plans? If, for example, the state institutes a payment cap and the center rate exceeds or is near the cap, would you be more inclined to delay implementation of additional services or increase staffing deemed advisable for meeting anticipated volume of services?

3. Medicaid budgets in most states are under serious review, particularly in the wake of state fiscal crises. In your state's review of Medicaid program policies and budget, have the FQHC provisions been subjected to special scrutiny?

5. Although Medicare is not a focus of our study, we are interested in knowing how you are planning for Medicare-FQHC. Are you planning to become a Medicare-FQHC? Do you plan to try to services to increase your Medicare beneficiaries? Are there any problems now with Medicare reimbursements.